Items 23a or 28a-f shi with the Mary

ŏ

natural

it of Health and Mental

permit. Page Department of Important: If any injury or

**Physician** 

/Medical

Examiner

burial-transit

as the

9 1

ō

detached

99

The law requires that the death pertificate be executed

or Attending Physician:

fo the Hospital

death.

hours after death uneral Director:

within 24 hours a pellil

à

Box 68760,

P.O.

of Vital Records,

Division

other treumatic

ò

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

event, the Medical Examiner next be notified

Director

Completed by Funeral

Be

ျှ

Examiner

Completed by Physician/Medical

Be

ို

Medical Certification;

9 Unknown

25. Was case referred to medical examiner?

1X Yes 2 □ No

27. Manner of Death

2 Accident

3 T Suicide

4 | Homicide

	1 - State Registrar AM	END ITEM	1 #22 PER FE	G828 2/09/04 GA	rtificate of	Death	Reg	J. No.	U mp	0000
Physician /Medical	Decedent's Name  Mark	e (First, Middi	(e, Last)	Dogo1i			2. Date of Death Month JANUARY	Day	Yeer 2004	3. Time of Death
Examiner	4a. Fecility Name (/ 6282 TUF				4b. City, Town, o	r Location of Death		4c. County		
Funeral Director	5. Social Security N		6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth March 29	°°1970		place (State or Foreigntry) York
land	Usual Residence of 10a. State		,	10c. City, Town or Lo	ocation					10d. Inside City Limit

Columbia Maryland Howard 10e. Street and Number 10f. Zip Code

1 XYes 2 □ No 10g. Citizen of What Country?

21046 United States 6282 Tufted Moss 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black White, etc. 1 Never Married 2 Married White 1 ☐ Yes 🏋 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ **Hospital** Medical Doctor

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sally Gundry Joseph Dogoli

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 414 Monaco Parkway, Denver, Colorado 80220 Stephanie Kroepfl, Sister

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Venice, Florida

Venice Memorial Gdns.2/9/04 21. Signature of Funer Service Licenses

22. Name and Address of Facility Ewing Funeral Home FARLEY's FUN.H.M. 140 East Venice Ave., Venice Florida 34285 M01113

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition Cardiac Arrhythmia resulting in death) Due to (or as a consequence of): Cardiac Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown

3 DEctopic pregnancy 5 Other (specify)

23d. Date of delivery Year Month Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 □ No 1 Yes

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE 3 DOA 28b. Time of

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30, 2004 OCME JANUARY

30. Name and address of person who completed ca e of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 THEODORE M.K 31. Date filed (Month, Day, Year)

State Registrar

FEB 0 9 2004

5 Pending

investigation

determined

6 Could not be

327 Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

			State of State Amend Item 23a per Dr., G	of Maryland 828,02/09/0	d / Depar 04dheert	tment of He ificate of D	ealth and Me leath	ental Hygien	e 2 0 0 1	03502
	Physici	an	1. Decedent's Name (First, Middle, Last)		DE	XTER		2. Date of Death  Month	ay Year	3. Time of Death
>	/Medic	al	PATRICIA  4e. Fecility Name (If not institution, give street and no	umber)	-	4b. City, Town, or L	ocation of Death	xuncor	c. County of Dea	th 19-15
	Examin	er	Jahno Hoexins	HODD	Ital	Dalti	ARAM		N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M XXF	7. Age (In yrs. Ia:		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 20, 1	r) 1926 Ma	thplece (State or Foreign ountry) ryland
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Inside City Limits
	Aary a-f sh	tor	Maryland Baltimore	Ва	ltimore	2				1 ☐ Yes 2 ☐ No
	or 284	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What C	ountry?
	s 23e	ral	11 Devon Hill Rd.	adam Evania II C	140.14	21210	0.1-1-2.76	4. V	U.S.A.	and an all disa
936	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If each 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Examble must be motified at	by Funeral	Armed F	2∏ No ive No	lf Y	as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 No	panic Origin? (Spec Mexican, Puerto R Specify:	ican, etc.)	14. Race - Am Black, Whi	
21215-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed	)	16a. Deceder	nt's Usual Occupati	on ring most of workin	16b.	Kind of Business	/industry
121	within ene. then	mpie		(1-4or 5+)	life. DC	O NOT use retired)			C	0
d 2	e filed within Il Hygiene. other than vent, the we		17. Father's Name (First, Middle, Last)		Mecha	anical En		(First, Middle, Maide	Company	Owner
lan.	should be nd Mental marked o	To Be	Harry John Stockum				Elizabe	eth	R	ieger
Maryland	and 2 should ealth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type, Print) Susan Cesare (Daughte	r )				Route Number, City	or Town, State,	Zip Code)
	ss 1 and of Health item 27		20a. Method of Disposition	cor	ace of Disposit		Da		Location - City or	
im	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Gree			ry 2/3/0			Maryland
Baltimore,	permit. Pages Department of I Important: If it sny injury or o once.		21. Signature of Funeral Service Licensee	ala	22. 1	Mitchell 6500 Yo	-Wiedefel rk Rd. Ba	d F.H. Ir altimore,N	nc. Maryland	21212
E			23a. Part1. Enter the disease, or complications/that shock, or heart failure. List only one cause on	caused he death. each line.	Do not enter	the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical			PRATION	Pneumo	onia				18 hours
2	Examiner		Due to	(or as a conseque		Pul mono	24 DISENSE	-		1/2
Ž.	*	ner		(or as a conseque		FULMONA	9 DISTANCE	<u> </u>		years
	ficate be executed physicien and is the burial-transit	Examin	Cause (Disease or injury that initiated events c.							
60,	be exicien a		Due to	(or as a conseque	ence of):					
68760,	ficate physics the	edicai	d							
Вох	death certific e attending p id for use as	N/M		atcome of pregnand		-			23d. Date of de	livery
P.O. B	0 0	Physician/M		birth 2 ☐ Fetal d Inant at time of dea nown		ctopic pregnancy Other (specify)			Month	Day Year
of Vital Records, P	Se us	by	Part II. Other significant conditions contributing to a CRITICAL AURTIC SYEN		ting in the und	erlying cause given	in Part I.	23e. Did tobacco		o the cause of death?
900	ne faw requir has been s ge 2 should	Completed	ISCHEMIC CARDIOMYO	PATHY				24a. Was an		utopsy findings available
Ä	The ate h	Com						autopsy performed?	death?	completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1		- 1/30		26. Place of Death	Check only one)		
of	d is	1: To	27. Manner of Death 28a. Date	Inpatient 2 El	R/Outpatient 28b. Time of		4   Nursing Hom	e 5 Residence		cify)
ion	Attending ir death. ector: After by the fune	atior	1 XNatural 5 ☐ Pending (Moi 2 ☐ Accident investigation	nth, Day Year)	Injury	28c. Injury a Work? M 1 \( \text{Ye}	s 2 🗆 No	,	,	
Division	or Attendater death I Director:	Certification:	3 Suicide 6 Could not be determined 28e. Plac	e of Injury - At hom ling, etc. (Specify)	ne, farm, stree	t, factory, office	28	If. Location (Street a City or Town, Sta		ural Route Number,
	Hospite 4 hours Funerel ely fille	edical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)	e best of my knowl casis of examination	rledge, death o	ccurred at the time, stigation, in my opin	, date and place, an tion, death occurred	id due to the cause( I at the time, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License r		29d. D	ate signed (Mont	h, Day, Year)
•		4	1 7772	MDN	AEDI4AZ	RES	-000	JA	NUARY 3	1,2004
(	18)		30. Name and address of person who completed cau	se of death (Item 2	23a) (Type, Pri	int)	VORTH MOL	FE STREET.	BALTIMUM	1,2004 LE,MD21287
2:	Sta	to	31. Date filed (Month, Day, Year) 32.1	NS MOPICIN	re respective	1001				0.100
	Sta Registr	_	FEB 0 9 2004		frest!					

			1- State of Maryland /	Depa Cer	artment rtificate	of H	ealth an Death	d M		giene Reg. No	Great Tell Ton	With the second	03500
Ì	Physic		1. Decedent's Name (First, Middle, Last)  Pennis Evans						2. Date of De Month	Da		ear	3. Time of Death
>	/Medi Examii		4a. Facility Name (If not institution, give street and number)		-		Location of D		Febru	7	County of n/a	Deeth	
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last.)  12 M 2 F  46  Usual Residence of Decedent	birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, De 05/06/	y, Year)		Count	ece (State or Foreign ry) Land
	e Maryland 8a-f show	Director	10a. State 10b. County 10c. City, To MD Prince Georges Laur		cation							10	od. Inside City Limits
	3a or 2		10e. Street and Number 15411 Arbory Way		10f. Zip (						izen of Wha	t Count	try?
900	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Exaraine roust be redilled at	by Funeral	11. Marital Status  11 Marital Status  12 Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	1	Vas Decede f Yes, speci			? (Spe	ecify Yes or No Rican, etc.)		14. Race Black, \	White, e	itc.
Maryland 21215-0036		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  M	(Give I	lent's Usual kind of work DO NOT use enance	done di retired)	tion uring most of	worki	ng		Airp		ustry
ryland	2 should be filed and Mental Hygi is marked other aumatic event,	To Be	17. Father's Name (First, Middle, Last)  Daniel E. Evans, Sr.  19a. Informant's Name/Relationship (Type, Print)	05 14-15-	- Add		Doro	thy	(First, Middle,	oury			
, Ma	ロチトラ								el, Mai				Code)
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 2008.		20a. Method of Disposition  1  Burial 2 Scremation 3 Removal from State  4 Donation 5 Other (Specify)	tery, crem Wash		er place itor	y 02	/08	/2004	La	ure1,	Mar	yland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee  EMJA D Wart	/(	501 Sa	ndy	_Sprin	g R		ure	Home	, In	nd 20707
8760,	Physician and busician and physician and physician and physician and strength and physician it was a physician and	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failbed. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons	e of):	rai					rest,		4	Approximate interval Between Onset and Death  LE LC YS  NE MONTH
P.O. Box 6	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic pred Other (spec					2	23d. Date of Month		/ Day Year
Ś	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cau	se giver	in Part I.	_			se contribut ⊒No 3 ⊑		cause of death?
al Reco	ician: The law re certificate has be rector, page 2 sho	Completed						_	24a. Was a autop perfor	sv	24b. Were prior death	to comp h?	sy findings available pletion of cause of No
Division of Vital Record	To the Hospital or Attending Physician: The la within 24 burs after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	atlon: To Be	25. Was case referred to medical examiner?  1   Yes   2   2   No	Outpatient Time of Injury		Other Linjury a Work?	4 ☐ Nursin	g Hon	(Check only or ne 5 Resid 8d. Describe h	ence 6		Specify)	
Divis	ital or Atterns after de ral Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, o	office		2	8f. Location (S City or Town	treet and n, State)	d Number or	r Rural I	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 [★Certifying Physician: To the best of my knowledge one)  2 □ Medicel Exeminer: On the basis of examination a and manner stated.	ge, death und/or inve	estigation, in	my opir	nion, death o	ace, a	d at the time, d	ate and	place, and	due to ti	ne cause(s)
	. To To Con	4	29b. Signature and title of certifier  M  M  M  M  M  M  M  M  M  M  M  M  M	D		icense r	3187	, ~		9d. Date	signed (M	onth, De	y, Year)
	7		30. Name and address of person who completed cause of death (Item 23a) Scircin Murthi, MD 2-2 Sci	) (Type, P	rint)					ore	, ME	3 1	1201
1	Sta Registr	100	31. Date filed (Month, Day, Year)  32. Registrar's Signature	4	1		~ .				-		-11

ORIGINAL

KEVIN FULLER UNK 04-024 04-00644 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

04	44		State of Maryland 1. State Unpend Item #23a,27,28a-f per me	I / Department of Health and M G82 <b>6:AtWdStetes</b> Death		ene 2004	03504
>	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  4a. Fecility Name (If not institution, give street and number)	1/er 4b. City, Town, or Location of Death	2. Date of Death Month January	Day 2004 23, 2004	3. Time of Death 1250 A M
2000	Funeral	ier	3815 Park Heights Avenue  5. Social Security Number  6. Sex 100 M 2 F  7. Age (In yrs. la	Baltimore	8. Date of Birth Month, Day, Y	N/A 9. Birth	nplace (Stete or Foreign unity)
,	ne Maryland 8a-f ehow	ector	Usual Residence of Decedent  10a. State 10b. County 10c. City,  MD Baltimore Wo	Town or Location Odlawn			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
36	be filed within 72 hours after death with the Maryland hal Hygiene. ed other than "natural", or Items 23a or 28a-1 chow event. The Maricel Examination that is the multified at	y Funeral Director	10. Street and Number  2454 Golders Green C  11. Marital Status  1 Drever Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 Dro If Yes, Give Year or Dates:	10f. Zip Code 2 1244  13. Was Decedent of Hispanic Origin? (Spell of Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	(	14. Race - Amer Black, White Specify: 13	rican Indian,
d 21215-0036	filed within 72 hour Hygiene. Hyer than "natural ent, Ins Manical Es	e Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12)  To Father's Name (First, Middle, Last)	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)  ASSISTANT Driver  18. Mother's Name	ng	b. Kind of Business/I	1
Maryland	s 1 and 2 should be I Health and Mental Item 27 Is marked o other traumatic eve	To Be	Jake Arco  19a. Informant's Name/Relationship (Type, Print)  Ruth White - Grandmother	Florine  19b. Mailing Address (Street and Number or Rura  2454 GOLOPES GCP:	Fuller	City or Town, State, Z	ip Code) MD 21244
Baltimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe once.		1 ☐ Burial 2 D remation 3 ☐ Removal from State	ce of Disposition (Name of netery, crematory or other place)  2+0 Crematory 3-6  22. Name and Address of Facility	20 - 04 00 - 270 FRE	c. Location - City or T HONSUITE	
	Physician /Medical		23a. Paris Enter the surface, or combications that caused the death, shock, in part fillure. List only one cause on each line.  Immediate Cause (Final disease of condition as Smoke inheresulting in death)	alation	BAUTO ir respiratory arrest	MD 210	Approximate Interval Between Onset and Death
8760,	Examiner	ical Examiner	Sequentially list conditions, flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence o	riea of):			
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	leath 3 Ectopic pregnancy		23d. Date of delive	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	1 Tes		bably 4 Unknown
Vital Records,	Physician: The law this certificate has ral director, page 2.8	Be Completed	25. Was case referred to medical examiner?  1.77 vs. 2.71 No. 1.75 Hospital:	26. Place of Death		d? prior to co death? I No Prior Yes	opsy findings available ompletion of cause of
Division of	r Attending ter death. irector: After of the fune	Certification; To	27. Manner of Death  1 Natural 5 Pending investigation  2 X Accident investigation  1 / 22/04  1 Inpatient 2 Let  28a. Date of Injury (Month, Day Year)  1 / 22/04	### 28c. Injury at Work?  0:42 PM 1 Ves 2X No  1e, farm, street, factory, office	P.Bd. Describe how Victum of	injury occurred  house fire and Number of Rue state) 3015 Park	At Scene  al Route Number Ave.
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl one)  2 Medical Exeminer: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, a	and due to the caused at the time, date	e(s) and manner as and place, and due t	to the cause(s)
<b>)</b>	To Wit		30. Name and address of person who completed cause of death (Item 2	O.C.M.E.		Date signed (Month, anuary 23,	
	Sta Registr		J. Date filed (Month, Day, Year)  FFR 0 9 2004  Samuel Segistrar's Signature Segistrar's Signature Segistrary	111 Penn Street, B	altimore,	Maryland	21201

			1 - For Amend Item 20c pe	State of Maryla r FH,G828,02709	nd/Depa 704dhb e	artment of rtificate of	Health a Death	and Mental Hy	/giene2 Reg. No.	004	03505
ı	n		1. Decedent's Name (First, Middle, Last)		<u> </u>			2. Date of D Month		Yeer	3. Time of Death
	Physici /Medic		Carolyn Ann Gullet					Januar	y 9, 2	004	9:20 A. M
	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town,	or Location of	of Death		unty of Death	
			Laurel Regional Ho		- for an foliate along	Laure If Under 1 Yea		24 Hrs. 8. Date of B			George
	Funeral Director		240-24-0127	M 2₹ F 92	s. last birthday) Yrs.	Months Days		Min. (Month, D August	ay, Year)	Cou	hplace (Stete or Foreign untry) outh Carolina
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Maryl f eho	ō	Mississippi Hanco	ck t	Javelano	4					1 X Yes 2 □ No
	288-	Directo	10e. Street and Number	CIC , W	averan	10f. Zip Code			10g. Citizen	of What Cou	untry?
	3a o	O E	136 Farrar Lane						USA		
	deat	Funeral		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	Hispanic Ori	gin? (Specify Yes or N , Puerto Rican, etc.)		Race - Amer Black, White	
21213-0030	filed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or Iteme 23a or 28e-f ehow sht, I'ra Middieal Examirael must be nutified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	i	1□Yes 2□X				ecity: Wh	
	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occ	upation e during mosi	t of working	16b. Kind	of Business/li	ndustry
V	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work don DO NOT use retir	ed)				
7	ygien ygien her th		12	Ø	Ho	nemaker	10 14atha	er's Name (First, Middl	Own .		
Maryland	0 = 0 5	Be	17. Father's Name (First, Middle, Last)				_		e, Maiden Sui	riame)	
2	should by and Menta	2	Charles Hatfields  19a. Informant's Name/Relationship (Type	o Print)	10h Maili	na Address (Stra	<u> </u>	vailable) er or Rural Route Num.	her City or Tr	own State 7	(in Code)
<u>8</u>	d 2 st th and 7 le n traun		Flint Gullett / Ne	•				ane, Laure			
	1 an Heali em 2	1 8	20a. Method of Disposition	-	Place of Dispo	sition (Name of	1	Date unk			Town, State unk
ē	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	matory or other pi h Crem		unk		, MD 207	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic er 900.8.		21. Signature of Fugeral Service License			2. Name and Add		y Fleck Fu			
Ď	Dee of the state o		Exemple ST	wan	7	601 Sand	v Spri	ng Road, L			
ľ			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final		ath. Do not en	ter the mode of dy	ring, such as	cardiac or respiratory			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Hypertensi		diovascu	lar Di	sease			Many Years
	Examiner				,						
ar.		Je	S uentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):						
	ate be executed hysician and the burial-transit	Examin	Cause (Disease or injury that initiated events								
Š	e exe ian a urial-l		resulting in death) Last	Due to (or as a conse	equence of):						
8/60,	ate b hysic the b	lical	d								
Õ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	N- 15							
XOD	eath certific attending p	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg	tel death 3	Ectopic pregnan			23d	. Date of delin Month	Day Year
j.	at the de by the a tached t	yslc	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown	death 5[	Other (specify)	-				
1	res that the igned by be detact	H.	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause (	given in Part I.	. 23e. Did	tobacco use	contribute to	the cause of death?
SD	uires sign ld be	d by	Hypertension, Ce	rebrosvascul	er Dis	ease,		1	Yes 2X∏N	lo 3 Pro	obably 4 [Unknown
Ö	w requir been si should (	Completed	Droumonia					24a. Wa	san 2	4b. Were auf	topsy findings available
Ě	The law cate has (	m d	Pneumonia					aut	opsy ormed?	prior to codeath?	completion of cause of
<u>a</u>			25. Was case referred to medical				26 Place	of Death (Check only	2 X No	1 🔲 Yes	2 XNo
>	ysician; s certific director,	To Be	avaminar?	ospital:	☐ ER/Outpatie	nt 3 DOA		rsing Home 5 Res		Other (Spec	cify)
Division of Vital Records,	or Attending Physician; ther death. Director: After this certifics in by the funeral director, i		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o	W	ury at ork?	28d. Describe			
Sio	death. ctor: A	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2		(0)		17
<u>&gt;</u>	s after d st Direct at Direct	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, offic	ө		(Street and N own, State)	umber or Hui	iral Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my keer: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurrad at the evestigation, in my	time, date an opinion, dea	d place, and due to the the time	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	40		29c. Lice	nsa number		29d. Date si	igned (Month	i, Dey, Year)
			11000	in del	>	D2	3181		Janua	arv 10	, 2004
			30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,						
	145/1		R. G. Bhujraj, M.	D. 704 Gorn	nan Ave	nue #T-1	, Laur	el, Maryla	nd 2070	37	
	Sta Regist		31. Date files (Honth Day, 2441) 4	32 Registra Sig	natura						
1	TIEGISI	451									

	9	State Amend Registrar			·						2. Date of De		Year	3. Time of Death
Physici /Medic		Tracie Da	awn Gai	mbrill							02	03	2004	9:15AM M
Examir	C	4a. Facility Name (If n	ot institution,	give street and num	nber)				Location of	of Death			ounty of Deeth	
		Gilchris			7 Ass //s	In a 4 hinth of a	Tow:		If Under	24 Hrs	8. Date of Bir		altimor	Ce place (State or Foreigr
Funeral Director		5. 500 19 500 19 19 19 19 19 19 19 19 19 19 19 19 19	54	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. 37	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 02/09	/1966	Cou	yland
M II		Usual Residence of D 10a. State	0b. County		10c. Cit	y, Town or Le	ocation						-	10d. Inside City Limits
r 28a-f show	to	MD	Ralt	imore	Wh	nite Ma	rsh							1 ☐ Yes 2X No
r 28a	Director	10e. Street and Numb					10f. Zip (	Code				10g. Citize	n of What Cou	intry?
23a or	a D	10403 V	incent	Farm Lan	e - Rea	ar	21	162				U.	S.A.	
CARSE DA	Funeral	11. Marital Status		12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Decede	ent of Hi	ispanic Ori In, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	o- 14	. Race - Amer Black, White	
	y Fu	1 Never Married		If Yes, Giv	0		1 ☐ Yes 2						pecify:	
	d by	3 ☐ Widowed 4	5. Decedent'	Year or Da	ites:	16a Dece	dent's Usual	Occup	ation			16h Kind	Wn: of Business/Ir	ite
rent, the Medic	Completed	(Specify	only highest	grade completed)		(Give	kind of work	done o	during mos	t of work	ing	100.14.10	0,000000	.doo., y
	E O	Elementary/Second	lary (0-12)	College (1	-4or 5+)	Но	usewif	e				Hom	emakin	J
event, tre	Bec	17. Father's Name (F	irst, Middle, L	ast)					18. Mothe	er's Name	e (First, Middle	, Maiden S	umame)	
	TO E	Gene Van	ce Lea	se					Mar	gare	t Ann S	Sams		
other traumatic ev		19a. Informant's Nam	ne/Relationsh	ip (Type, Print)			-				al Route Numb			
ner tr				brill (hu		_			Farm		e – Rea Date			arsh, MD211
5		20a. Method of Dispo 1 X Burial 2 □		3 □Removal from :	State	Place of Disponentery, cre	matory or oti	her plac					ation - City or T	
5		`4 □Donation 5			Hol	ly Hil								, Maryland
sny injury or other QDCe.		21. Signature of Fund	Frail Service L	Cassal	ر.						F. Las Kingsv			l Home, P. <i>l</i> 1087
1		23a. Part1. Enter the	disease, or	complications that conly one cause on e	aused the deat	th. Do not en	ter the mode	of dyin	g, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between
ian		Immediete Cause (F disease or condition			12	@ SA S	T (	A	nce	2				Onset and Death
cal ner		resulting in death)		Due to (	or as a consec	quence of):			-					0
ier		Sequentially list cond	ditions,	b	or as a consec	warno offi								
	Examiner	Sequentially list conditions, leaving to immicause. Enter Underly Cause (Disease or in	riediate ying iiury	000101	or as a conside	puer ce ory.								
	xan	that initiated events resulting in death) La		c. Due to (	or as a consec	quence of):								
	calE			d										
	Completed by Physician/Med	IF FEMALE: 23b. Was decedent		23c. If yes, out	come of pregn	ancy	⊒Ectopic pre	agnancy	,			23	d. Date of deliv	
	sicia	in the past 12 m			ant at time of		Other (spe						Month	Day Year
	Phy	9 Unknown							in Daniel		22a Did	tobacca un	a contributo to	the cause of death?
	b	Part II. Other signific	ant conditio	ns contributing to di	satti but not 19:	sutting at the	andenying ca	ruse giv	en in raiti			Yes 2		bably 4 Unknown
	eted										-			
	JQ I										24a. Was	s an opsy ormed?	prior to c death?	opsy findings available ompletion of cause of
											1 ☐ Yes	200 No	1 🗆 Yes	2 No
	Be	25. Was case referre		Hospital:		75000000000		Oth			th (Check only		Downer (Con-	Morning
Š	.: To	1 ☐ Yes 2 ☐ N 27. Manner of Death	10	28a. Date	Inpatient 2 of Injury	28b. Time		Bc. Injur	y at		ome 5 Res 28d. Describe	-		my) of organis
	tlor	1 Natural 2 Accident	5 Pendin- investig		th, Day Year)	Injury	М	Wor 1 🗆	nk? Yes 2. □	No				
	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could r	ned 288. Place	of Injury - At t	nome, farm, s	treet, factory	, office			28f. Location	(Street and own, State)	Number or Ru	ral Route Number,
	Certification;	4 _ Homicide		Dullai	ng, etc. ( <i>Spec</i> i	(Vi					Ony or re	Juni, Oldio,		
completely filled in by the funeral director, page z	Medical (	29a. Certifier (Check only one)	Certifyin	g Physician: To the Examiner: On the b	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurred anvestigation,	at the tir	me, date ar pinion, dea	nd place, ath occur	and due to the red at the time	cause(s) a , date and p	nd manner as blace, and due	stated. to the cause(s)
эшріе	Med	29b. Signature and	itle of certifier		A)		29c	. Licens	e number			29d. Date	signed (Month	, Day, Year)
		· M	Att	ma the	Cu.	un	6	)2.	1 de	720		Feb	rum	3,2004
	D	30. Name and addre	ss of person	who completed caus	se of death (Ite	m 23a) (Type	, Print)	0		, 0	01		245	3,2004 204
	^	1 / 1	1:/	// //										
		M-A-6	2iley	GAM	Registrar's Sign		· Clas	erl	e 57	. 6	relto.	Ma	212	04

			For 1 ≈ State Registrar	Stat	e of N	Marylan	d / Depa	artmen rtificat				lental H		ene . No.201	04	03507
			Decedent's Name (First, Middle	e, Last)					-			2. Date of	Death	Day	Vaar	3. Time of Death
	Physicia		Frank	G	a11c	wav						Feb.	7,	2004	Yeer	9:30 A M
	/Medic Examin		4a. Facility Name (If not institution					4b. City,	Town, or	Location of	of Death			4c. County	of Death	
	LXaiiiii	C1	Upper Chesapeak	e Medic	a1 (	Center		В	el A	ir				Harf	ord	
-	Funeral		Social Security Number	6. Sex	7.		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, July	Birth Day, Y	(ear)	9. Birthp	place (State or Foreign htry) Maryland
	Director		217-30-7475	X M 2□	]F	79	Yrs.	Wichtins	Days	110013		July	30,	1924		Maryland
	p ,		Usual Residence of Decedent  10a. State 10b. County			10c Cit	y, Town or Lo	ocation							1	10d. Inside City Limits
	anyla shov	5				100. 010										1 □ Yes 2 ⊋ No
	8a-f	Directo	Maryland Harf	ord			Be1	Air 10f. Zip	Codo				100	z. Citizen of W	/hat Cou	21
	with t			- C	Dog	د		101. 21	2101	5			1	nited		•
	J within 72 hours after death with the Maryland idea. Jiene. Than "natural" or Items 23a or 28a-f show It a Madical Examinatinations to a confilted at	Funeral	719 S. Fountai			nt Ever in U	S 13	Was Dece			iain? (Sp	ecify Yes or				can Indian,
	ter de Item	Ľ.	11. Marital Status  1  Never Married 2   Mar	Arm	ed Force	s?	.5.	If Yes, spe	cify Cuba	n, Mexicar	n, Puerto	ecify Yes or Rican, etc.)			k, White,	
5	Irs at	by F	3 ☐ Widowed 4 ☐ Divorced	If Ye	s, Give			1 🗆 Yes	<b>2</b> ₹ No	Specify:				Specify	Wh	ite
5-0036	2 hou	ted		nt's Education			16a. Dece	dent's Usu	al Occupa	ation	A - 4 de	·	16	Bb. Kind of Bu	siness/In	dustry
212	within 72 ene. than "nat	ple	(Specify only higher Elementary/Secondary (0-12)		eted) ege (1-4)	or 5+)	life.	kind of wo DO NOT u	se retirea	during mos I)	t or work.	ing		'ommun i	+ 37 T	awnService
7	filed within t Hygiene. other than rent, it a M	Completed	2nd				Grou	nds K	Ceepe	r					Ly	awiibel vice
פ	e filed was Hygien of the th	Bec	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	,		aiden Sumam	θ)	
Maryland	should be I ind Menta! I marked or umatic eve	P	Unk	cnown								Unkno	wn			
a	0 0 00	1 3	19a. Informant's Name/Relations	hip <i>(Type, Prin</i>	t)		19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Nui	nber, (	City or Town,	State, Zip	Code)
	1 and 2 Health tem 27 other tra		Beatrice Dean				719_9			in Gr						y1and21015
altimore,	0 0		20a. Method of Disposition  1 Darial 2 Cremation	3 □Remova	from Sta	10	Place of Dispo cemetery, cre	matory or o	ther plac			Date .		c, Location -	,	
Ĕ	Pages nent of ant: If It ury or o		'4 □ Donation 5 □ Other (5			Wes	st Arur	ndel (	Crema	atory	2/9	/2004	(	dentor	ı, Ma	ryland
a	permit. Page Department Important: It any injury o		21. Signature of Funeral Service	Lioensee			AT	2. Name ar	nd Addres	ss of Facili Ft Re	<sub>ty</sub> gist	rv				
m	8928		Juanta 9	1401	mad		7.5	526 C	onne	11ey	Driv	e, Sui	lte	E Hand	over,	MD 21076
			23a. Part I. Enter the disease, o shock, or heart failure. List	t only one caus	e on eac	h line.							y arres	it,		Approximate Interval Between
	Priysician	8 1	Immediate Cause (Final disease or condition		Co	renu.	nce of):	rter	y .	Dise	250					Onset and Death
	/Medical		resulting in death)	a. D	ue to (or	as a consec	nce of):	/								
	Examiner		Sequentially list conditions	b. ——												
	<b>₽ =</b>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>Į</b> D	ue to (or	as a consec	quence of):									
	ecute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	- 1- (						-					
ő	e exe		leading in death, cast		ue to (or	as a consec	quence or):									
8760,	rate be executed physician and the burial-transit	dicai		d												
ũ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Me	IF FEMALE:	020 1611	a sutan		••••							201.0	6 d - P	
Вох	ath co	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗆	Live birth	me of pregna n 2 ⊟Feta	aldeath 3	⊒Ectopic p		,				23d. Dat	e of deliv nth	ery Day Year
P.O.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknow	it at time of one	death 5	Other (s	овсту)				-			
<u>а</u>	that the de led by the a detached f		Part II. Other significant conditi	ions contributir	g to deat	th but not res	sulting in the L	undertvina o	ause div	en in Part I	l.	23e. D	id toba	icco use conti	ribute to t	he cause of death?
ļs,	ires tha signed I be det	by		m 3 - 5 -7.	_				_			1	☐ Yes	2 🗆 No	3 🗆 Prot	pably 4 inknown
Ö	w require been signature	Completed										040 14		24h 1	Mara auto	opsy findings available
Sec.	has t	иp										24a. W	utopsy orforme		prior to co death?	impletion of cause of
<u> </u>	: The											1 Ye	s 2[	3No 1	Yes	2□ No
Division of Vital Records,	Attending Physician: Th r death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medica examiner?	Hospital			/		Oth			h (Check on				
of	Phys this al dir	P	1 Yes 2 No		1 □ Inp	-	ER/Outpatie	-	OA 28c. Injur					ce 6 Doth		(y)
n C	ding 1	Ö	1 Natural 5 ☐ Pendi	ing	(Month,	Day Year)	Injury	, M	Wor	k? Yes 2 □		200. 2000.	00 110	mjury coour.	-	
<u>si</u>	death death tor:	icat	3 Suicide 6 Could	tigation I not be	Place of	flnium - Ath	some farm st			.00		28f. Locatio	n <i>(Str</i> e	et and Numb	er or Rur	al Route Number,
<u>≥</u>	or Attendate death Director:	Certification;	4  Homicide determ	mined 200.	building	etc. (Speci	ome, farm, st		y, o			City or	Town,	State)		
_			29a. Certifier 1 Certifyi	ing Physician:	To the b	est of mv kn	owledge, dea	th occurred	at the tir	ne, date ar	nd place.	and due to t	he cau	use(s) and ma	nner as s	stated.
	24 h 24 h Fur etely	edical	(Check only 2 Medica one)	I Examiner: Or	the bas d manne	is of examina	ation and/or in	rvestigation	n, in my o	pinion, dea	ath occur	red at the tin	ne, dat	e and place,	and due t	o the cause(s)
	To the Hospital within 24 hours To the Funeral completely filled	Me	29b. Signature and title of certific	959						e number				d. Date signed		
	- s + ō		1						03	501	2		F	ebruin	ry 8	12004
	h		30. Name and address of versor	n who complete	d cause	of death (Ite	m 23a) (Type	Print)					-		/	21014
	9		J. Keulin	LYNCH	1 /	n D	2 /	No.	12	AVC	s 4	301	Air	, M	d.	21014.
	Sta	ate	31. Date filed (Month, Day, Year			gistrar's sign	ature		B	9						121
	Regist		F	EB 0 9	2001	Lin	ature	y A	204	San						S <sub>o</sub>

Galloway, Frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 State
Registrar Amend Item#5perFHG828 2/12/04 EW Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 9:40 PM 2004 ebruar /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Medical Baltimore Maryland Lenter ot If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2ਊF 71 Director July 21 1932 -Maryland Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Modical Examinar must be untillian at 1 Tyes 2 No Md. n/a Director Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 600 Light Street 21230 U.S.A. Be Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2V No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 8 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Health and Mental Pant: If item 27 is marked or Alfred Gawronski Mary Matilda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Spano (Daughter) 8063 Catherine Ave. Pasadena, Md. 21122 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy \(Cross Cemetery) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 02/10/04 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave. Baltimore, Md. 21230 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ~ 3 month Jepsis **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-tran attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) the i 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. Be Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has funeral director, page 2 autopsy 2 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury af Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dafe and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certified 7 664 tebruary 6. 2004 auniers 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Chauncey T. Jones, MD 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State oaks Registrar FFR 0 9 2004

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Maryia	•	rtificate of	Death	Mental Hy	giene Reg. No. 2	004	03509
	Physic /Medi			RUPP					2. Date of De Month FEB.	$\overset{Day}{3}$ , 2	Year 004	3. Time of Death 12:55 AM
Ź	Exami	ner	4a. Facility Name (If not institution, give					4b. City, Town, o			y of Death	
		_		WES HO			If Under 1 Year	CRISE			ERSE7	
	Funeral Director		5. Social Security Number 6. S  218-01-9400  Usual Residence of Decedent	ex □M 2☐F	7. Age (in yrs	3 Yrs.	Months Days		(Month, D	719 17, Yee <i>r)</i> 121	9. Birthpl Count MAR	lace (State or Foreign try) (LAND
	aryland show		10a. State 10b. County		10c. C	ity, Town or Lo	cation				10	Od. Inside City Limits
	with the Marylar s or 28a-f show be notified at	ţċ	MD SOMER	SET		WEST	ΓOVER					1 ☐ Yes 2 No
	or 28	ire.	10e. Street and Number			,,=-	10f. Zip Code			10g. Citizen of	What Count	ry?
	ath w	lal	6700 ELMO DRYD					871		USA		
020	72 hours after death with the Maryland natural', or items 23a or 28a4 show dical Externment De profilled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	2 <b>⊠</b> No		Vas Decedent of I f Yes, specify Cub I □ Yes 2⊠ No	Hispanic Origin? ( pan, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)	5- 14. Ra Bla Specia	ce - America ick, White, e fy:	
9-0	2 hours atural', ical Exc	fed	15. Decedent's Ed	ucation		16a. Deced	lent's Usual Occu	pation		16b. Kind of B		
21215-0020	within iene. than "	Completed	(Specify only highest gra Elementary/Secondary (0-12) UNKNOWN	de co <i>mpleted)</i> College (1- UNKNO	,		kind of work done OO NOT use retire	pation during most of wo d)	orking			SPECIALTY
P	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle			
Maryland	ges 1 and 2 should be filed tof Health and Mental Hyg If item 27 is marked other or other traumatic event,	P	CHARLES ENGL						NOWN			
Mai	d 2 sh th and 7 is rr traun		19a, Informant's Name/Relationship (7 WILLIAM GRUPP	Гуре, Print) / SON				t and Number or F RYDEN R		•		•
	es 1 and of Health item 27		20a. Method of Disposition	/ 50N	20b.		sition (Neme of natory or other pla		Date	20c. Location		
ē	Sages ent of nt: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		late		natory or other pla CEMET		6/04	BALTI		
Baltimore,	permit. Pag Department Important: If any injury o		21. Signature of Funeral Service Licen		OA			SK <sup>†</sup> F <sup>acil</sup> FUN				MD.
<u>~</u>	Dem Depa Impo any ii		Eugene )-	Cart	> {	12	201 DUN	DALK AV	E. BAL	ΓIMORE	, MD.	
>	Physician /Medical Examiner	er	23a. Part1. Enter the disease of companies shock, or heart failure. East only of the shock of th	a. Cut	de An		erebi	al F	2	0	i	Approximate Interval Between Onset and Death
	icete be executed physician and s the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (	or es a consequ	uence of):	•		.,		
68760,	cete be physicians the buri	dicai	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (d	or as a consequ	ience of):					
×	certificanding plans as t	Me	C	d							<u>i</u>	
. Box	death e atter	icia	Part II. Other significant conditions co	ntributing to dea	th but not res	sulting in the un	derlying cause on	ven in Part I	23h Did	ohacco usa co	ntribute to 1	the cause of death?
, P.O.	that the	by Phys	Essential	2 2	/	rten		on in Part 1.				ably 4 Unknown
Records,	Physician: The law requires that the death cartificate be this certificate has been signed by the attending physicianal director, page 2 should be deteched for use as the burner.	Completed b		/	10					an autopsy rmed?	avail	e autopsy findings leble prior to pletion of cause eath?
æ	The la	E							101	res 2 kk No		Yes 2. No
of Vital	ilan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					26. Place of De	ath <i>(Check only</i> o	ne)	L	
<u>&gt;</u>	hysic his ce il dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 □ In		ER/Outpatient	3□ DOA Oth	er: 4 🗷 Nursing l	lome 5□Resid	lence 6 □Oth	er <i>(Specify)</i>	
ion	ath. r: After tl		27. Manner of Death  1  Natural 5 □ Pending 2 □ Accident investigation	28a. Date of (Month)	Injury Dey Yeer)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2∐No	28d. Describe	now injury occur	red	
Division	To the Hospital or Attending Physician: The law within 24 bours effectedath.  To the Funeral Director: Affect this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o building	f Injury - At h g, etc. <i>(Sp</i> ec <i>ii</i>	ome, farm, stre fy)	et, factory, office		28f. Location (S City or Tox	Street and Numb m, State)	er or Rurai i	Route Number,
	ne Hospi n 24 hou ne Funer	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the b ner: On the bas and manne	is of examine	owledge, death etion and/or inve	occurred at the tirestigation, in my o	ne, date end place pinion, death occu	, and due to the a	cause(s) and ma date and place,	inner es stat and due to t	led. he cause(s)
	Vithir Comp		29b. Signature and title of certifier	7 -	>	-2	29c. Licens	e number		29d. Date signe	d (Month, Da	ay, Yeer)
	6		Jugari /	2. 15.	elle	270		9505		02-0	03-	2004
	K	1	ati. Name and address of person who of GREGORIO M. BE					ERRY D	R. SAL	ISBURY	, MD	21801
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	pistrar's Signa	A Liver	y hour		1	7.	,	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 7

1 - State Amend Item 7 per FH,G828,02/09/04dhb Certificate of Death

Registrar

Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician FEB** GINSBURG 03 2004 12:45A FANNIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** HOSPICE OF BALTMORE - GILCHRIST CENTER TOWN BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 94 93 Yrs. AUG 23, 1909 MARÝLAND Director 215-40-1581 Usual Residence of Decedent 10b. County N/A Maryland 10c. City, Town or Location BALTIMORE 10d. Inside City Limits 10a. State the Medical Examiner must be nutified at MD 1 Yes 2 No Director 10f. Zip Code 21210 10g. Citizen of What Country? 10e. Street and Number 1190 W. NORTHERN PARKWAY, #503 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 X Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil Health and Mental H tem 27 Is marked otl Be **PODOLSKY ROSE** STEINSCHLEIFER WILLIAM other traumatic ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai <u>once</u>. 2 SUDBROOK CT. BALTIMORE, MD BILL GINSBURG (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Pages 1 OHEB SHALOM MEM. PÄRK 2/5/04 REISTERSTOWN, MD 5 Other (Specify) 4 Donato of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 Particular the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cruy on each line. Approximate Interval Between Onset and Death mmediate Cause (Final ext parietal stroke Physician weeks disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 X Natural after death. 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 125205 February 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Poulto Md 2020x Riley 6701 BMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004

DHMH 17 Rev 1/2001

Registrar

MY STIC

à

5

BUR

n

State of Maryland / Department of Health a	and Mental Hygiene
Certificate of Death	Reg. No.

If Under 1 Year | If Under 24 Hrs.

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last) UNICE

5. Social Security Number

226.24.2539

2. Date of Death February 06, 2004

3. Time of Death 1953 P <sup>™</sup>

4a. Facility Name (If not institution, give street and number) 11507 Harford Road

4b. City, Town, or Location of Death Glen Arm

Days

4c. County of Death Baltimore

**Funeral** Director

r 28e-f show

8 23a or ō

ō

natural

other

Pages 1 and 2 should be finent of Health and Mental 3 soft: If item 27 is marked of

permit.

rtent: If its njury or o

Importent: t any injury o once.

the Me then

other traumatic event.

filed within 72 hours after

Maryland 21215-0036

altimore.

Director

Be

၉

Usual Residence of Decedent 10a. State 10b. County BALTIMORE MARYLAND

10c. City. Town or Location

Yrs.

GLEN ARM

7. Age (In vrs. last birthday)

8. Date of Birth (Month, Day, Year) Hours Min. ANUARY

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

Birthplece (State or Foreign Country)

PENNSYLVANIA

10e. Street and Number

ROAD ARFORD

1 ■ M 25 F

6. Sex

2105/

10f. Zip Code

14. Race - American Indian,

10g. Citizen of What Country?

1150 Completed by Funeral 11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AIRDRESSET

22. Name and Address of Facility

16b. Kind of Business/Industry

SMETOLOG'

17. Father's Name (First, Middle, Last)

TARLAND

18. Mother's Name (First, Middle, Maiden Sumame,

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 KOAD

EVANS

10 20a. Method of Disposition

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of

Date 20c. Location - City or Town, Stete competery, crompatory or other place)

ANS FUNERALAIR FEB. 10, 2004 FOREST

FUNERAL

\* 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

EPCO HARFORD ROAD, PARKVILLE, MD 21231 Do not enter the mode of dying, such as cardiac or respiratory arrest,

HARFORD

CHAPEL Approximate Interval Between Onset and Death

23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)

1000

complications hat us

JAM UVUS Due to (or as a consequence of):

the deat

USBAND

Due to (or as a consequence of):

Due to (or as a consequence of)

**Physician** /Medical **Examiner** 

use as the burial-transit

ŏ

detached the e

page 2 should been

funeral director,

the 1

in by t

filled

completely

certificate has

After

within 24 hours after death. To the Funeral Director: A

signed by

attending physician

P.O. Box 68760

Division of Vital Records,

or Attending Physicien:

the Hospitel

The law requires that the death certificate be

Examiner

Physiclan/Medical

Completed by

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last

IF FEMALE

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an

autopsy øerformed: 1 Yes

2 □ No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? XXYes

2 🗀 No 27. Manner of Death

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28a. Date of Injury (Month, Day Year) 5 Pending

28b. Time of M 28c. Injury at Work?

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scene 013250 (5)

1 Natural 2 Accident 3 Suicide 4 Homicide

investigation 6 Could not be determined

7:23 ( -6-04 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

DRIUSWBY FW YDM)

1 ☐ Yes 2 🖼 No

PASSENGEN IN CAR IMPACT WITHFRYED 28f. Location (Street and Number or Rural Route Number, City or Town, State)

11507 HOREFORD W BALTWORF CO. HM

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

LORELL

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) February 07, 2004

TOWN 30. Name and address f person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) FEB 0 9 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of Ma	aryland	-	artmen <i>tificat</i>			and M	lental Hy	giene	/11111	4 03	512
	Physici	an	1. Decedent's Name (First, Middle, Last,	)							2. Date of De Month	Da	y Year	3. Time o	of Death
	/Medic		Lee Hildebrandt				r				February	-	04	5:00	A M
)	Examin	er	4a. Facility Name (If not institution, give	street and number)					Location of	of Death		- 1	County of Dea	ath	
			20339 Gore Mill Road  5. Social Security Number 6. Se	v 7 Ag	e (In yrs. la:	st hirthday)	Free!		If Under	24 Hrs.	8. Date of Bi		altimore	tholace (State	or Foreign
	Funeral Director			M 2□F 69	-	Yrs.	Months	Days	Hours	Min.	April 10	ay, Year)	L Ralt	thplace (State ountry)	tsz MD
			Usual Residence of Decedent								24421 10		T	THE CITY	Cy , L D
	how	_	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	
	Be-f s	Director	Maryland Baltimore		Fræla	and								<u> </u>	2 □ No X
	hours after death with the Maryland turel', or Items 23e or 28e-f show at Exantimer aust be multified at	Die	10e. Street and Number				10f. Zip						izen of What C	ountry?	
	s 23e	Funeral	20339 Gore Mill Road	12. Was Decedent	Ever in II S	12 \		.053	ispanic Ori	ain? (Sne	ecify Yes or No	USA	14. Race - Am	erican Indian	
	Item	Ě	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?		. 13.1	f Yes, spec	offy Cuba	in, Mexicar	n, Puerto	Rican, etc.)		Black, Whi		
38	urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 <b>∑</b> (No	Specify:				Specify: Wh	ite	
Ŏ	72 ho netur	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	dent's Usua	al Occupa	ation during mos	t of worki	na	16b. K	ind of Business	/industry	
21	within iene.	d d	Elementary/Secondary (0-12)	College (1-4or 5		life. L	DO NOT us	se retired	()		•				
121	be filed within 72 hours after death with the Marylan ital Hyglene. Id other then "neturel", or liems 23e or 28e-f show or other the market Examilise and the multiple of the second second.		12 17. Father's Name (First, Middle, Last)	2		Install	er		19 Mothe	re Name	(First, Middle		ephone Co		
Maryland 21215-0036		Be	Leonard A Hildebrandt								herry	i, maraeri	Jumame)		
Ž	d 2 should be th and Menta 7 Is marked treumatic e	P	19a. Informant's Name/Relationship (7)			19b. Mailir	na Address	(Street a				er. City o	or Town, State,	Zip Code)	
≅	h ar h ar reu	İ	Donna Labadie-Waldt	,,,			-				d, Md. 2		, , , ,	,,	
ē,	of Healt item 2 other		20a. Method of Disposition		20b. Pla	ce of Dispo				-	ate		ocation - City or	Town, State	
Ê	<b>₽</b> ○ <del>=</del> ≥		1 ☐ Burial 2 反 Cremation 3 ☐ F	Removal from State	1	o Crema				7 -6 2	004	Balti	more, Mar	vland	
Baltimore,	artn orte inju		21. Signal re of Funeral Service Licens	88	0.130	22	. Name an	d Addres	ss of Facilit	v			J. Land	,	
<u>m</u>	Per Imp any		Mathon Moss	In Cha	JOOL	1 74	01 Bel	air I	oad Ba	ltim	re,Maryl	and 2	1236	,	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused ne cause on each lir	the death. ne.	Do not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Be Onset and	tween
1	Physician		Immediate Cause (Final disease or condition	a Meta	stat	TC.	Dicu	dde	V I	Car	cer		y.	4 ye	ars
1	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):								J	
		<u>.</u>	Sequentially list conditions, if any leading to immediate	b Due to (or as	a conseque	ence of):									
	uted 3 ansit	Examiner	Cause (Disease or injury												
oʻ	exectan an a		resulting in death) Last	Due to (or as	a conseque	ence of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		d											
Ö	ing ph e as t	Med	IF FEMALE:	=7, 17			7/11-	- 72							
Вох	eath certifi attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetel c	leath 3	Ectopic pr						23d. Date of de Month	_	Year
<u>o</u> .	t the de by the a ached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	un 5∟	Other (sp	өспу)							
<u>α</u>	that the by detac		Part II. Other significant conditions co	ntributing to death b	ut not result	ting in the u	nderlying c	ause givi	en in Part I		23e. Did	tobacco i	use contribute t	o the cause of	death?
Records,	quires n sign ald be	d by									×	Yes 2	□No 3□P	robably 4 🗆	Unknown
2	s been si s should	Completed									24a. Was			utopsy findings	
Re	The lav	E O									auto perfe 1 ☐ Yes	psy ormed? 2 ₩ No	death?	completion of o	cause or
Vital	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				-		26. Place	of Death	(Check only	_/			
of V	Physicien: this certific ral director,	卢	1 ☐ Yes 2X No	Hospital: 1  Inpatie	- P	R/Outpatien	-	4 4	40140	irsing Ho			6 □Other (Spe	ecify)	
D C	ding P h. After t funera	ë.	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Ye <i>ar)</i> 2	28b. Time of Injury		8c. Injury Worl	k?		28d. Describe	how inju	y occurred		
isio	Attending r death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	unu - At hom	o farm str	M oot factor		Yes 2□	-	28f Location /	Street an	d Number or A	tural Route Nun	nher
Division	after all in by	Certification	4 Homicide determined	building, et		10, 12(111, 5(1	eer, racion	, onice			City or To			0.0711001011011	11201,
×	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the			sician: To the best											
	he Hc n 24 l he Fu sletely	Medical	(Check only 2 Medical Examione)	iner: On the basis of and manner sta		on and/or in	vestigation	, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(	\$)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier				290	License	number	121	501	29d. Da	te signed (Mon	th, Day, Year)	, j
	X		7 Cony Ou	Dams	m /	MID		IVI	) T	JOV	100	Fel	onuar	16,20	xy
	10,		30. Name and address of erson who c	ompleted cause of d	leath (Item 2	23a) (Type,	Print) L	1016	· of	mo	argia	nd	bruar 13a	1	20
	01		31. Date filed (Month, Daylo Years) O. 8	282_Registr	ar's Bignatu	V 1 100 AL	2	1-6	5,0	216	ene.	>+	109	MOZ	201
	Sta Registi		FEB 0 9 2004	Morra	Jan Maria	1							•		,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 5, **Physician** 5:00 AM S Hubbe 2004 Eugene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 6502 Cleveland Avenue Baltimore N/A Birthplace (Stete or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 XM 2 ☐ F May 30,1931 220-20-6011 MD. Director 72 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23e or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Director N/A Baltimore City MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6502 Cleveland Avenue 21222 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 11 Years Longshoreman Steamship Trade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Philip Hubbe Anna Janowicz 27 is marked traumatics 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau WIFE HUBBE 6502 MD. 21222 CLEVELAND I DA 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State 20a. Method of Disposition 9 cemetery, crematory or other place) FeB 1 ■ Burial 2 □ Cremation 3 □ Removal from State SACRED HEART of BALTO ms JC215 \* 4 □ Donation 5 □ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22-Name and Address of Facility uneval 7110 Sollers Point Home of Bundalken 7110 oinT Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of **Physician** DAARASEN /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctoric pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown n signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably cate has been significant categories. Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 Yes 2 No To the Hospital or Attending Physicien: : After this certification and funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after community to the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN MATTHEW KAGHIMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFB 0 9 2004 Registrar

			1 - For State Registrar	State of Mar	ryland / Dep <i>Ce</i>	artment o rtificate d	f Health an of Death	d Mental Hy	giene 2	004	03511
			Decedent's Name (First, Middle, Li					2. Date of De	ath		3. Time of Death
	Physic /Medi		ELFZaBETH	HICLF	ENDIN	16		- Month FEBRU	My 4	200 Y	2:56 AM
	Examir		4a. Fecility Name (If not institution, gi MERC MCCL	re street and number)	ter	4b. City, Tow	n, or Location of D	eath Nら	4c. Col	inty of Death	none
	Funeral Director		216-34-3124	Sex 7. Age ( 1□ M 2 <b>X</b> F 66	(In yrs. last birthday) Yrs.	If Under 1 Ye Months Da		Hrs. 8. Dete of Bir Min. (Month, Da November	19,1937	9. Birthr Cour MI	place (State or Foreign htry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or Lo	ocation				1	Od. Inside City Limits
	Mary 9-f ah	tor	MD. N/A		Baltin	nore					Y Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen	of What Cour	ntry?
	s 23a		1133 South Bonsal			212			USA		
920	hours after death with the Maryland tural, or flems 23a or 28e-f ahow at Executing from the collined at	by Funeral	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of the second of Yes, specify 0 1 ☐ Yes 2 1 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Cuban, Mexican, Po	? (Specify Yes or No Jerto Rican, etc.)	E	Race - Americ Black, White, ecity: Whi	etc.
21215-0036	77 mail	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most of	working	16b. Kind o	f Business/Ind	dustry
21	D D > -	Соп	12 years	2 years		capp Le	eader		Balti	more C	ounty
Maryland	a la ba	Be	17. Father's Name (First, Middle, Last Sebastiano Sudano					Name (First, Middle, na Impall		name)	
Ž	should by nd Menta marked marked	ို	19a. Informant's Name/Relationship		19b. Mailir	ng Address /Stre		Rural Route Number		em State Zin	Code
	1 and 2 s Health ar em 27 ls	0 2	Michael Hillferd	ing husban				treet, Ba			
Baltimore,	Pages ent of nt: If it ry or o		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Dispo cemetery, crer Sacred Hear	natory or other p	olace) Fel	oruary , 2004	20c. Location Dunda	on - City or To	wn, State
Balt	permit. Pag Department Important: any injury o		21. Signature of Furieral Service Lice	nnelly	22	Name and Ad Connelly 1110 Sol	dress of Facility Funeral	Home Of nt Road,	Dundal.	k.P.A.	21222
#5			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the							Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition resulting in death)	a 5 mall	BOWE	LIN	FARCY	ion		K	Onset and Death
87	/Medical Examiner		Toolain g in dolling	Due to (or as a c	consequence of):	× 1	BSTNU	02/2			
18		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	consequence of):	VL U	100110	CYION			NEWWOOD
K	icate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events	с							
9	be exection a	EX	resulting in death) Last	Due to (or as a c	onsequence of):						
58760,		edical	•	d							
.O. Box (	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	23c. If yes, outcome of particles of the common of the com	Fetal death 3	Ectopic pregnar Other (specify)				Date of deliver Month	ry Day Year
<u>a</u>	that the	/ Ph	Part II. Other significant conditions of	contributing to death but n	not resulting in the ur	iderlying cause	given in Part I	23e. Did to	bacco usa co	notribute to the	e cause of death?
Records,	w requires been sign should be	eted by							es 2□No		
	: The law cate has t page 2 s	Completed						24a. Was a autop perfor	sy med?	o. Were autop prior to com death? 1 \( Yes \)	sy findings available apletion of cause of
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	i samin		Data and	eath (Check only or			
Division of Vital	or Attanding Physician: after death. Director: After this certific in by the funeral director.	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. In	4   Nursing	Home 5 Resid			)
Divisi	ol or Attandi after death. I Diractor: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		· At home, farm, stre Specify)			28f. Location (S City or Tow	treet and Num n, State)	mber or Rural	Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director.	edical C	29a. Certifier Certifying Ph (Check only one) 2 Medical Exer	ysicien: To the best of m niner: On the basis of ex and manner stated	amination and/or inv	occurred at the estigation, in my	time, date and pla y opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and r date and place	manner as sta e, and due to	ited. the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier			29c. Lice	nse number	2	9d. Date sign	ned (Month, D	ay, Year)
			of gold	1	2	03	5036	100	EBIN	AM L	1, 2004
	15		30. Name and address of person who	1 2 -	h (Item 23a) (Type, F		0		0.0		
R.	Sta	te (	31. Date filed (Month, Day, Year)	32. Registrar's	Signature Signature	16/6	all III	mont i	720	2-120	) /
	Registra		FFR 0 9 2		man by	Som	K1 .				

		1	For Stete Registrar	State of Maryland / (		lealth and Me	ental Hygie	_
/M	/sicia ledica	n il -	1. Decedent's Name (First, Middle, Lass Route 1)  4a. Fecility Name (If not institution, give	Hall	4b. City, Town, c	or Location of Death	2. Date of Death Month	Day Year 3. Time of Death 22:59 p.m.
Fune Direc			Howard Cours 5. Social Security Number 6. So	ox 7. Ago (In yrs. last bil	p. C	Olumbel If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, ) June 17,	/ear) 1911 9. Birthplace (State or Foreign Country) Maryland
ne Maryland	offiled at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, Tow Clarks	ville		100	10d. Inside City Limits  1 ☐ Yes 2☐ No XX
r death with the	ermust be n	<u>e</u>	10e. Street and Number  12201 Hall Shop Ro  11. Marital Status	oad  12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code  21029  13. Was Decedent of Highest Specify Cub		U	S • A •  14. Race - American Indian, Black, White, etc.
15-0036 172 hours after death with the Maryland *netural; or Items 23a or 28a-1 show	lical Examin	፭	1 DNever Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra	1  Yes ANNO If Yes, Give Year or Dates:  Jucation 16a  de completed)	1 ☐ Yes 2 🛣 No  Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation	g 16	Specify: White  Sb. Kind of Business/Industry
	vent, the Mus	റ്⊦	Elementary/Secondary (0-12)  Grade 8  17. Father's Name (First, Middle, Last)	Coltege (1-4or 5+)	lerk	18. Mother's Name	(First, Middle, Ma	Howard County Gov.
Maryland and 2 should be filt the and Mental H;	other traumatic event, the M	္	Herbert Elmer Hall  19a. Informant's Name/Relationship (1)  Dorothy Stull /	Type, Print) 19t	o. Mailing Address (Street			City or Town, State, Zip Code)
O 85 =	yury or	13-	20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification 2). Signature of Funeral Service Licer	Removal from State 20b. Place of cemete  Mt. Z	of Disposition (Name of ary, crematory or other pla ion Church (	Cem. Feb 1	1, 04	Oc. Location City or Town, State Highland, Maryland
Bal permi Depa Impo	any injury once.		23a. Part1. Enter the disease, or comshock, or heart failure. List only	/ M00770	313 Talbot	ess of Facility Funeral Ho t Avenue ng, such as cardiac or	Laurel,	Maryland 20707
Prinyaid American and American	iner	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence b. Due to (or as a consequence c. Due to (or as a consequence d. Due to (or as a consequence	e anes	dist is nia testinal	trais	t bleedig
P.O. Box 6871 nat the death certificate to by the attending physic	detached for use as th	Completed by Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnand 5 Other (specify)	ey .		23d. Date of delivery Month Day Year
cords, P.O  w requires that the	should be deta	ted by Ph		brillation, C.		ven in Part I.  Part Ly	1 🗆 Yes	accoluse contribute to the cause of death?
Vital Rec	or, page 2 sh	e Comple	Any Country  25. Was case referred to medical	poidui		26. Place of Death		ZNo 1 □ Yes 2 X No
		ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of 28c. Injury	ther: 4 Nursing Hominy at prk?	ne 5 ☐ Resider 8d. Describe hov	ice 6 ⊡0ther ( <i>Specify</i> ) v injury occurred
DIVIS spital or Att ours after de	filled in by t	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify)	ge, death occurred at the t	ime, date and place, a	City or Town,	use(s) and manner as stated.
Division of To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this	completely	Medical	(Check only 2 Medical Example)  29b Signature and title of certifier	niner: On the basis of examination a and manner stated.	nd/or investigation, in my	opinion, death occurre	d at the time, dat	d. Date sinned (Month, Day, Year)
20	0	-	30. Name and address of person who Sizan Hodi	0,M) 5005 S	(Type, Print) Ignal Bel	l In. C	Carles	uille MD 21029
Re	Sta egistra		31. Date filed (Month, Day, Year)  FR 0 9 2	32. Registrar's Signature	& home	E1 *		

	1 - For State Registrar		Ce	ertificate d	of Death			g. No.	2004	ICCU
:	1. Decedent's Name (First, Middle, La	ast)					Date of Death Month	Day	Yeer	3. Time of Death
ian ical	Carla Marie	Hardesty					ebruary			12:24 a M
ner	4a. Facility Name (If not institution, gi				n, or Location of	of Death			County of Death	
	1039 Harrison Dr			Laur		24 Hre o	Data of Righ		nce Ge	-
г		Sex 7. Age (In yrs	s. last birthday Yrs.	Months Da		Min. Mai	Date of Birth Month, Day, Ch 4,	Year) 194	9. Birti Con Was	nplace (State or Foreig unity) hington, D
	Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or L	ocation						10d. Inside City Limits
_				Location						1 ☐ Yes 2 ☐ No
ecto	MD Prince (	George's	Laurel	10f. Zip Coo	10		10	o Citiza	en of What Co	
ā	10e. Street and Number 1039 Harrison Dr:	ivo		207			10	•	5.A.	unity:
erai	10.39 Mallison Di.	12. Was Decedent Ever in	US 13			gin? (Specify	Yes or No-		4. Race - Ame	ricen Indian,
by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ Xio If Yes, Give Year or Dates:		. Was Decedent If Yes, specify (		, Puerto Rica	to Rican, etc.)  Black, White, etc.  Specify: White			
d b			162 Dec	edent's Usual Oc	cupation		1	Sh Kin	d of Business/I	Industry
Completed	15. Decedent's 8 (Specify only highest g	rade completed)	(Giv	e kind of work do DO NOT use re	ne during most	t of working	"	סט. אוווי	d OI Dusillessyl	illousity
E	Elementary/Secondary (0-12) Grade 9	College (1-4or 5+)	Sale		00)			Ret	ail	
	17. Father's Name (First, Middle, Las	S()	Dare	<u> </u>	18. Mothe	er's Name (Fi	rst, Middle, M			
Be C	Alfred Dorn	•			Edna	a Mae I	550C			
ဥ	19a. Informant's Name/Relationship	(Type Print)	19b Mai	iling Address (Str				City or	Town, State, Z	(ip Code)
	Ronald E. Hardes									
-	20a. Method of Disposition		Place of Disc	position (Name o	f	Date	2 P	Oc. Loc	ation - City or	0707 Town, State
	1 ☐ Burial 2XX remation 3			ematory or other undel Cr		Feb 13	2004	0.7	lenton,	MD
	* 4 □ Donation 5 □ Other (Special Service Lice	,,					-		icircon,	110
	21. Signature of Pulleral Service Cic			Boharust					4	000000
	330 Bort Sator the disease of co			313 Talk	dving such as	enue .	Laurel,	, Ma	irviand	20707 Approximate
	23a. Pert1. Enter the disease, or co shock, or heart failure. List on	y one cause on each line.	2	11,01 (110 111000 01	J, g, 000 00	02.2.20	op	- 1,		Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	<sub>a.</sub> Metastati		n Cancer	:					15 Months
	resulting in doubly	Due to (or as a conse	equence of):							
<u>_</u>	Sequentially list conditions,	b. Due to (or as a conse	ornegine offi-							
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (01 23 2 00.30	equorite or,							
Examiner	that initiated events resulting in death) Last	cDue to (or as a conse	equence of):							
cal E			,							
		d								
/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy					2,	3d. Date of deli	NAC.
lan	23b. Was decedent pregnant in the past 12 months?	1∐Live birth 2∏Fe	ital death 3	Ectopic pregn				2.	Month	Day Year
Physician/Med	1 ☐ Yes 2 █¥io 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	10a(II )	i ☐ Other (specif)						
Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying causi	given in Part I.		23e. Did toba	acco us	e contribute to	the cause of death?
t by							1 🗆 Yes	s 2 🔯	No 3□Pr	obably 4 Unknow
etec							04-146		045 14/	
Completed	•						24a. Was an autopsy perform	, !	prior to death?	topsy findings availab completion of cause of
Ö			<u>-</u>				perform 1 ☐ Yes 2	EXNo	1 🗆 Yəs	2 <b>X</b> X <sub>1</sub> 0
Be	25. Was case referred to medical examiner?	Hospitali					heck only one			
2			☐ ER/Outpati	1980	Other: 4 Nu					cify)
Certification:	27. Manner of Death 1XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	28a. Date of Injury (Month, Day Year)	28b. Time Injury	/	Injury at Work?		Describe how	w injury	occurred	
cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be -			1 ☐ Yes 2 ☐ I		1 (Ct			
riff	4 Homicide determine	28e. Place of Injury - At building, etc. (Spe	home, farm, s cify)	street, factory, of	fice	281.	City or Town,	eet and State)	Number or Ru	iral Route Number,
						1				
Medical	29a. Certifier   (Check only 2 Medicel Ex	Physician: To the best of my k aminer: On the basis of exami	nowledge, de nation and/or	ath occurred at the investigation, in it	ne time, date an my opinion, dea	nd place, and oth occurred a	due to the car it the time, da	use(s) a te and p	and manner as place, and due	stated. to the cause(s)
e	one)	and manner stated.		29c Li	cense number		29	d Date	signed (Montl	n Dev Yearl
-	29b. Signature and title of certifier	COO.								
Σ		V 2	MA	D	18219		T T	Febr	112rt 9	, 2004
2	Xen	0		l D	10217		1 -		dary	,
_	30. Name and address if person wh	2344	em 23a) (Typ	e, Print)	go, Mar		20744		dary	, 2001

DHMH 17 Rev 1/2001

ORIGINAL

the contest

Patient known us Moneth Huderson

*
68760,
Вох
P.0.
Records,
Vital
o
Division
,

		Please Type or Print in Blac		-		
			Department of Health and M	lental Hygiei	ne2004	03517
		1 = State Registrar	Certificate of Death	Reg.	No.	00011
Physic		1. Decedent's Name (First, Middle, Last)  Monette Henderson		2 1	Day Yeer	3. Time of Death
/Med Exam		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tebruary	4c. County of Death	111
		Sinai Hospital of Bultimo			NA	
Funera Directo		5. Social Security Number   6. Sex   7. Age (In yrs. last bit   156 - 36 - 2156   1 M 2 F   5 T   Usual Residence of Decedent	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye.	ar) D. Birth Cou	plece (State or Foreign intry)
Aaryland I ehow	ō	10a. State 10b. County 10c. City, Tow	m or Location Ba Himore	£ 5		10d. Inside City Limits
with the had a or 28a-	Funeral Director	10e. Street and Number  1701 Fictive Days Apt. 307	10f. Zip Code Z1Z-17	10g.	Citizen of What Cou	ntry?
death ma 23	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
inition (e), Interpretation Z.I.Z.I.3-0030  init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatth and Mental Hygiene.  ortant: if item 27 is marked other than "natural", or itema 23a or 28a-1 show injury or other traumatic event, the Medical Exertical must be inclined as	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	· iloan, etc.)	Specify: Bl	ack
in 72 h	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workillife. DO NOT use retired)	ng 16b.	Kind of Business/Ir	ndustry
d with giene (giene ier the	Com	Elementary/Secondary (0-12) College (1-4or 5+)	unemployed		NIT	
Should be filed with Management of Management Hygiene marked other their Imatic event, trees	To Be	17. Father's Name (First, Middle, Last)  UNKA(N)	18/ Mother's Name	(First, Middle, Maid Moor	len Sumame)	
Mally d 2 sho th and 1 7 is ma trauma		19a. Informant's Name/Relationship (Type, Print) 19th Benjamin Henderson - Son Z	Mailing Address (Street and Number or Rura	I Route Number, Cit	y or Town, State, Zij	Code) 08234
os 1 an of Heal fitem 2		20a. Method of Disposition 20b. Place o	of Disposition (Name of cry, crematory or other place)	ate 20c.	Location - City or To	own, Sir te
Dottillore, permit. Pages 1 at Department of Hea Important: If item eny injury or other		4 Donation 5 Other (Specify)	Bion Cemetery 2/1	404 La	ndshowne	Maryland
permit. Pag Department Important: I		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Fark 3512 Frederick	te. Bal:	timore, N	c F.S. 1.A.
	L	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	1	r respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medica	1	disease or condition resulting in death)  a. Due to (or as a consequence	Gowel			1 Month
Examine	8	Sequentially list conditions, if any, leading to immediate b Due to (or as a consequence	of):			
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
rou, le be executed ysician and e burial-transit	sai Ex	resulting in death) Last Due to (or as a consequence	of):		To the state of th	
OO tificate ig phys as the		d				
The Cold ds, F.C. BOX 00/00,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mohths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
that the ed by detact		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	i o use contribute to t	he cause of death?
requires een sign	ed by	Hypertension		1 ☐ Yes	2 □No 3 □ Prob	pably 4 Unknown
The law rette has be sage 2 sho	Completed			24a. Was an autopsy performed?	prior to co death?	ppsy findings available mpletion of cause of
stan: artifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death		10 100	-5.10
Physic this ce	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou		ne 5 🗆 Residence		(y)
nding ath. r: After	ation		Time of 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	.og. Describe now in	july occurred	
al or Atters after des la Director	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	281. Location (Street City or Town, Sta	and Number or Rura ate)	N Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medicel Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place, a dor investigation, in my opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
To the within To the comp	M	29b. Signature and Little of certifier	29c. License number		Date signed (Month,	
7		Ma Com	RES-PPG	Feb	round 6 ,-	2004
1		30. Name and address of person who completed cause of death (Item 23a)  **Leanty Maik Jackson , MD 51.	(Type, Print) NAI HOSPITAL OF BAL	TIMORE		
	tate					
Regis	trar	31. Date filed (Month, Day, Year)  FEB 0 9 2004  32/Registrar's Signature	Marie Contraction of the Contrac			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4, FEBRUARY LINDA ERIN HOLZMAN 2004 1:20 P /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 21 FOXMOOR COURT OWINGS MILLS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) dec. 26, 1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 54 Yrs 217-50-3394 Director md Usuel Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 21 FOXMOOR COURT 21117 U.S.A. Funeral 12. Was Decedenf Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 le marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) SOCIAL WORKER STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM HOLZMAN **FLORENCE** OXMAN ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 le MARC HOLZMAN / BROTHER 2606 WASHINGTON AVENUE - CHEVY CHASE 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Renhoval from State BALTIMORE HEBREW CEM. 5 Other\_(Spedity 2/6/2004 REISTERSTOWN, MD \* 4 Dona 21. Signald 22. Name and Address of Facility SOL LEVINSON & BROS. INC 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 7 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes 2 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death 6 Could not be 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) 29c. License number eted cause of death (Item-23a) (Type, Print) 6569 32. Registrar Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03519 Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Rose Marie Harris February 5. 2004 3:45 AM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 86 Yrs 212-12-0155 11/14/1917 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show th end Mental Hygiene. It is marked other than "naturel", or itsma 23a or 28a-1 shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Baltimore Director Overlea 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 4300 Cardwell Avenue Apt. 222 21236 Funeral U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours aftar 1 Never Married 2 Merried ☐ Yes 2X No Yes, Give Maryland 21215-0020 1 ☐ Yes 2x No Specify: Specify: δ White 3☑ Widowed 4 □ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk 12 Social Security Admin. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Dominick Loangelo Josephine Mistretta 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health e important: If Item 27 is any injury or other tra-25 Beverly Drive Hillsborough, New Jersey ()8844 of Disposition (Name of Date 20c. Location - City or Town, State Jesse Harris/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2/9/04 Baltimore, Maryland Parkwood 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service License any ir 6415 Belair Road Baltimore, Maryland 21206 23a. Part. Enter the diseast, or constitution to the australiance the Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CHRONIC OBSTRUCTED PULMONARY DISEASE Examiner Due to (or as a consequence of): Examine The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): attending physician for use es the burie P.O. Box 68760 Physician/Medical the Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Division of Vital Records, þ Aftar this certificeta has been signe funerel director, page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yes 2 No 28b. Time of Injury 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending 1 Naturel 1 Yes 2 No investigation death. within 24 hours after death.

To the Funeral Director: A completaly filled in by that 2 Accident tha 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide the Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D43725 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Registral

State

DR. TARIQ MAHMOOD

9 2004

31. Date filed (Month, Dey, Year)

FEBRUARY

ROSE HARRIS

32. Registrar's Signature

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARY FEB IHNAT 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERITAGE DUNDALK NURSING CENTER BALTIMOLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1 □ M 2 PF 205-03-6085 8 Director JAN10, 1921 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BAUTIMORE MD. Be Completed by Funeral Director DUNDALK 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SORVICE CUSTODIAN 8yrs ame (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) MARTHA DAVA.... 219b. Mailing Address (Street and Number 19a. Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
2 Onature of June Service Licensee DUNDALI SONNELLY FUNELLY HOME OF DUNGALK 2110 SOILERS POWT RD. 24222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Isease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner or Attanding Physician: The law raquires that the death certificate ba exacutad been signad by the attending physician and should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ briknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy performed 1 ☐ Yes 2 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this taral Diractor: After th 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Month, Day, Year) 32. Registrar's Signature State FEB 0 9 2004 Registrar

			1 - For State Registrar	State of Maryland		rtment of		ne 20	04 0352	
	Physic		1. Decedent's Name (First, Middle, Last	Lacovor	10			2. Date of Death Month FEBRUARY		3. Time of Death Yeer 2024 11:17 AM
	/Medi Examii		4a. Fecility Name (If not institution, give Saint Joseph			4b. City, Town,	or Location of Dea	son	4c. County o	
 42	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday) Yrs.	Months Day		. (Month, Day, Y	919	9. Birthplace (Stete or Foreigr Country)
	the Maryland 28a-f ahow putified at	Director	10a. State 10b. County  10e. Street and Number	10c. City,	Town or Loca	moni		10-	0.00	10d. Inside City Limits 1 ▼Yes 2 □ No
9036	hours after death with the Maryland tural', or Itema 23a or 28a-f ahow all Expr. it at must be publified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 DX'es 2 □ No If Yes, Give Year or Dates:		as Decedent of Yes, specify Cu	Hispanic Origin? ( lban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		A - American Indian, White, etc.
121215-0036	d within 72 jiene. r than *nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Deceder	nt's Usual Occ nd of work don O NOT use retir	e during most of we red)	orking		100
Maryland	d 2 should be filed th and Mental Hyg ? Is marked othe traumatic avent,	To Be	F-	acovone	19b. Mailing	Address (Stree	Carr	ame (First, Middle, Mai	Lon	bardi
Baltimore, Ma	Pages 1 and 2 ent of Health a ent: If Itam 27 Is ry or other tra		Elizabeth eg  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State 20b. Pla	ace of Disposit metery, crema	tion (Name of the plant)	itory 2	Timonium	MY	20193 ity or Town, State
Ba	Departm Departm Importa any inju		21. Signatur of Fund ral Service Licens  22. Part er the disease, or complete	I harch	I	Name and Add	W1230	Mid-Vall	ey Dr.	Jessup, PA 18434
8760,	Physician / Medical physician and physician and physician and physician and physician sill physi	ai Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	CARDIC ence of):	)MYORA		о от гозрівают в позі,		Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.  3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetel of 4 □ Pregnant at time of deal 9 □ Unknown	leath 3 □Ed	ctopic pregnand	су		23d. Date of Month	,
S, T	w requires that the been signed by th should be detache	ρχ	Part II. Other significant conditions con	ntributing to death but not result	ting in the unde	erlying cause g	iven in Part I.			ute to the cause of death?
Vital Record	The law ate has b page 2 sl	Completed	HEMOSIDEROSIS					24a. Was an autopsy performed 1 Yes 2 2	? dea	re autopsy findings available or to completion of cause of th?  Yes 2 2 No
of Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No	lospital: 1 <b>∭</b> Inpatient 2 ☐ E	R/Outpatient	3□ DOA O		ath (Check only one)	6 □Other	(Specify)
Division	Attending r death. sctor: Alter by the funer	Certification:	27. Manner of Death  1 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)	tab. Time of Injury		]Yes 2 □No	28d. Describe how in 28f. Location (Street City or Town, St	and Number	or Rural Route Number,
2	Hoapital or 24 hours afte Funeral Dir stely filled in I	edicai Cer	29a. Certifier 10x Certifying Physical Check only one)	sician: To the best of my knowiner: On the basis of examination and manner stated.	edge, death or on and/or inves	ccurred at the t	ime, date and place opinion, death occ	and due to the cause	a(s) and mann	er as stated. I due to the cause(s)
,	To the within 2 Complete	Med	29b. Signature and title of certifier	land on		a a	se number	29d.	210	Month, Day, Year)
_			30. Name and address of person who co  ROON F' IM M.  31. Date filed (Month, Day, Year)		ER DRI	•	JSON MAI	RYLAND 21	204	
	Sta Registr	-	on bate med (Month, Day, reat).	oz. Hegistrar s agnatu	L	8	9.			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JOHNSON WILLIE MAE FEBRUARL 2001 12:05 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL SAMARITAN BALTIMOR 4000 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) October 25,1910 ALABAMA **Funeral** 422-32-3164 93 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at Nes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1713 Poplar Grove 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homes permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other treumstic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Lee Fannie Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1713 Poplar Grove Baltimore, Kelly P. Parker / Son MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Berial 2 Cremation 3 Removal from State \* 4 Donation 5 □ Other (Specify) Baltimore, MD Woodlawn Cemetery 2-12-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylic Funeral Home 638N.Gilmor St. Balto,MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MEVMONIA Physician /Medical Due to (or as a consequence of): **Examiner** Si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): burial-transit the attending physician and Physicien: The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24e. Was an autopsy performed? Yes 2000 1□ Yes 25. Was case referred to medical 28. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00 58 913 Manishe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOULEVARD BALTIMORE LOCH RAVEN 5601 MANISHA BAHL MD MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month **Physician** Year lurdan 1515 homas /Medical 2004 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Baltimore gnes 05 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** IDM 20F 215-80-4630 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, the Madical Example traumat be notified at 1 Pres 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filled within 72 hours at Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or any injury or other traumatic avent, the marked other pages. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Şegondary (0-12) College (1-4or 5+) SERVICE Case Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JORDAN Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) ulamay Cordelia Ave Balto, MD 21215 Jordangrandmother 5334 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State Metro Crematory \* 4 ☐ Donation /5/☐ Other (Specify) 22. Name and Address of Facility Iton Pass Balto, mo 23a. Part. E e the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock relear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final disease r condition resulting in death) Pnysician 0 Ca /Medical Due to (or as a consequence of) Examiner Six uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit that initiated events has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. In nunet 6 frese Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown eno 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an mone this certificate no Division of Vital 1 Yes 21000 or Attending Physician: 25. Was case referred to medical examiner?

1 Tyes 2 No Be 26. Place of Death (Check only one) Hospital: 2 Other: 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

9

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2004

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

grom i.

07,200

		1 - For State Registrar		e of Ma	arylan				ealth a			Reg. No	C. U	04	03	524
Physic		1. Decedent's Name (First, Middle, VELMA	JACO	BS							2. Date of De Month	Da	y 4	Year 4		of Death
/Medi Exami		4a. Fecility Name (If not institution, Johns Hapkin	give street an	d number)	nedia.	16.4	4b. City,	^	Location of			-/-	. County	of Death	N/A	
Funeral Director			6. Sex 1 ☐ M 2 ☐	7. Ag	e (In yrs. 1	last birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	y, Year)	924	Count	ece (State ry) tucky	e or Foreign
death with the Maryland ms 23a or 28a-f ahow Imat be notified at	Director		altimor	re	10c. City	, Town or Lo			]	Dunda	alk				1 🗆 Ye	City Limits es 2⊠No
with the	Dire	10e. Street and Number 2908 Plainfie	ld Road	9			10f. Zip		21222			-		What Count State		
after or Ita	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Armo	Decedent ed Forces? Yes 2 🔯 I s, Give r or Dates:			Was Dece f Yes, spe	dent of Hi cify Cuba		igin? (Spe n, Puerto l	ecify Yes or No Rican, etc.)		14. Rac	ce - America ck, White, e	an Indian, etc.	
within 72 hours ene. than "natural",	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade comple	eted) ege (1-4or 5	5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done d se retired	ation during mos )	st of workii	ng	16b. K	16b. Kind of Business/Industry			
be filed that Hyging of other	o Be Corr	17. Father's Name (First, Middle, L	1 Yea			Chie	f Re	gista	18. Mothe		(First, Middle,	Maider	Johns Hopkins Hospita Maiden Sumame)			ospita.
re, Maryle s 1 and 2 should f Health and Mer tem 27 is marke othar traumatic	Ĭ	19a. Informant's Name/Relationsh Cheryl Atkins		,) 1ghte1	c				and Numbe	er or Rura	Route Number	er, City o				21231
Pages 1 a ment of Hez ant: If item ury or otha		20a. Method of Disposition  12☐Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		from State	0	lace of Dispo emetery, crer rrison	natory or	other plac			ate 2/10/20			City or Tov		s,MD
baltimo permit. Pages Department of Important: If i any injury or page.		21. Signature Funeral Service L				22 D	Name a uda –	nd Addres Ruck	s of Facilit Fune:	Yal F	Home of	Dur				
Pnysician /Medical		23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Unconsidered the mode of dying, such as cardiac or respiratory arrest, block or cause on each line.											ута		Approxim Interval B Onset an	nate Between d Death
death certificate be executed to attending physician and mind of or use as the burial-transit of	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter undertrying Cause (Disease or injury that initiated events resulting in death) Last	c. Di	onge ue to las Chron ue to (or as	a consequence	e her uence of): 15 che	mic	fail heri	ure,	iseas	icerbat e .	i-n	•	3	Veav	K
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/nths? 1 ☐ Yes 2 € No 9 ☐ Unknown	1 () l 4 () l	s, outcome Live birth Pregnant at Unknown	2 Fetal	death 3	Ectopic p Other (s							te of deliver	y Day	Year
law requires that the de-	þ	Part II. Other significant condition	s contributing	to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I	l.		obacco Yes 2		tribute to the		if death?
The The ate he	Completed										24a. Was autor perfo 1 🗆 Yes			Were autop prior to com death? 1 ☐ Yes	sy finding apletion of	s available cause of
Or VICAL P Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	1 Nnpatie	ont 2 🗆	ER/Outpatier	nt 3 🗆 D	Othe	200		ne 5 ☐ Resid		6 (70th	or (Specify	1	
T grand	⊢	27. Manner of Death    Natural 5   Pending investig		Date of Inju (Month, Da		28b. Time of Injury	_	28c. Injury Work		2	28d. Describe I				/	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	20d 20e.	Place of Inj building, et	ury - At ho c. (Specif)	ome, farm, str	eet, factor	y, office		2	28f. Location ( City or Tou	Street ar wn, State	nd Numb e)	er or Rural	Route No	umber,
he Hospi in 24 hou he Funer pletety fill	edical	29a. Certifier 1 Certifying (Check only one)	xaminer: On	To the best the basis o I manner st	f examina	wledge, deatl tion and/or in	vestigation	n, in my or	oinion, dea	nd place, a ath occurre	and due to the ed at the time.	date and	d place,	and due to	the cause	
To t With To t	Σ	29b. Signature and title of certifier	M		~;	mo	29	c. License	e number 25-0	000			-	d (Month, E		)
6		30. Name and address of person REZA YAGHMAI	who completed	O EW.	tern	Ave	Print)	iltin	nove,	, m	) 217	224				
St Regist	ate trar	31. Date filed (Month, Day, Year)	0 9 20													

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Carolyn 200 Year 1:00 30 an. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Georges TMORE If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 6. Sex Sex 1□ M 2☑ F 7. Age (In yrs. lest birthday) 53 Yrs. Birthplace (State or Foreign Country) **Funeral** Maryland Davs 218-46-681 Director Usual Residence of Decedent 72 hours after deeth with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or flems 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No TMONE Funeral Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 520 Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 600 Completed by 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic averages." 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0,12) College (1-4or 5+) unemployed Grade 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Sturais (ROTAR 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) -SISTEN Crimson Tree Joyce Warson Edgeword C 20b. Place of Disposition (Neme of cemetery, cremetory or other place, 20a. Method of Disposition
1 □ Burial 2 ☑ Cremetion 3 □ Removal from State Date 20c. Location - City or Town, State Metro Cremater Pe 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Egneral Service Lie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner certificate has been signed by the attanding physicien end irector, page 2 should be datached for use as the buriel-trensit Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es a consequença of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No eral Director: After this certificatiled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospitel: Yes 2□ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27 Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturel 5 Pending investigation 1 Tyes 2 □ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier -7921 6 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Melvin nelinales 2809 31. Date filed (Month, Dey, Year) 32 Registrer's Signature State

ORIGINAL

DHMH 16 Rev 6/95

Registrar

	1	For State Registrar AMEND ITEM #10g	State of Maryla					giene 20	04	03526	
Physician	1	1. Decedent's Name (First, Middle, Last)	Jones				2. Date of De Month		Year O4	3. Time of Death 6.00 P M	
/Medical Examiner		la. Facility Name (If not institution) give str	eet and number)		4b. City, Town,	or Location of Deat	-	4c. County	of Death	ore	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday) 95 Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs	8. Date of Bir Month, Da	th y. Year 908	<b>Eguintry</b>	ce (State or Foreign	
aryland ehow		Usuel Residence of Decedent 10a. State 10b. County	10c. (	City, Town or Lo	cation Baltimos		3		100	1. Inside City Limits  1 W Yes 2 \( \) No	
with the Marylan to 28s-1 show be notified at	חופרור	Maryland 1911  10e. Street and Number  1039 Ashburtor	st		10f. Zip Code	21716		10g. Citizen of W	Vhat Country		
South of the state	בומום		. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	specify Yes or No to Rican, etc.)	- 14. Race Blac	- American k, White, etc		
15-0036 15-0036 172 hours att	Š	3	If Yes, Give Year or Dates:	16a. Deced	1 ☐ Yes 2 ☑ No	upation			Specify: Black  b. Kind of Business/Industry		
1287, 2004 (2) 1800  be filed within 72 hours after death with the Maryland hall hygiene.  did other than "natural" or teme 23a or 28a-1 ehow event, the Medical Examinat must be notified at Re-Commission by Europea Director.		(Specify only highest grade of Elementary/Secondary (9-12)	College (1-4or 5+)	(Give	kind of work doni OO NOT use retir Ho M	e during most of wo	rking	NIA	-	.,	
laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Common To Re Common aumatic event, the Mental Common aumatic event aumatic	0 0 0	Tames Campb	ell				ne (First, Middle,	Maiden Sumam	e)		
ore, Maryla strainer, maryla strand 2 should if Health and Mer traumette other traumette		19a. Informant's Name/Relationship (Types Theyesa Waddy	, Print) - MicC2	19b. Mailir	g Address (Street) Parson	S AVE.	gaj Route Numbe	41.	State, Zip C	Z1207	
Baltimore, Maryland 21215-0036 Sentimore, Maryland 21215-0036 Sentit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or may injury or other traumatic event, the Medical Examples.  To Re Completed by E		20a. Method of Disposition  1		1 1	sition (Name of natory or other of MeM. R	ace) x 2/3	Date 104	Arbutus	City or Town	n, Stete	
Baltimore, Maryland 28h permit. Pages 1 and 2 should be flist bepartment of Health and Mental Hy Important: If tiem 27 is marked othe eny injury or other traumatic event, once.		21. Signature of Fuperal Service Licenses	Ken	34	Name and Add	ress of Facility to,	Ave. Bu	avis & Ci	mary.	lura 21229	
Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	,	er the mode of dy	- 0	or respiratory ar	rrest,	l lr	opproximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)  Sequentially list conditions,  b.	H y	pert	ens cir	~			i i	gene	
5), executed executed in and inal-transit	Yallille	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a conse	editeuce ot):							
		L <sub>d</sub> .									
P.O. Box 6876 nat the death certificate be by the attending physicial letached for use as the burnstic lan/Medical	CIGILLINIC	IF FEMALE: 23c 23b. Was decedent pregnant in the past 12 months?		23d. Date Mon	of delivery						
ords, P.O. Borequires that the death requires that the death one signed by the attermould be detached for the provincial and the physicial area.	y r II ya	1 ☐ Yes 2 No 9 ☐ Unknown  Part II. Other significant conditions contr	9□ Unknown		Other (specify)	iven in Part I.	23e. Did to	obacco use contri	bute to the	cause of death?	
	ופנפת						1 □ Y 24a. Was			ty 4 □Unknown y findings available	
+ a d	0	25. Was case referred to medical				26 Place of Dec		osy primed? di 2/10 No 1	rior to comp eath?	letion of cause of	
	2	examiner? 1 Yes 2 No  27. Manner of Death	spital: 1  Inpatient 2 2 28a. Date of Injury (Month, Day Yeer)	ER/Outpatien	1 3 DOA	ther: 4 🗆 Nursing H	lome 5□ Resid			Hospice	
∩		Natural   5   Pending	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	M 1[	]Yes 2 □No	28f. Location (5 City or Tow	Street and Numbe	er or Rural R	Route Number,	
Division  To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 11/21 Certifying Physic	tian: To the best of my king: On the basis of examin	nowledge, death	occurred at the	time, date and place	and due to the	cause(s) and man	nner as state	ed.	
To the to To the To the Complete		29b. Signature and title of certifier	and manner stated.		29c. Licer	ise number		29d. Date signed	(Month, Da	y, Year)	
Jo		30. Name and address of person who com	p) ted cause of sear (Ite	em 23a) (Type,	Print) ACC	hale	St. Ba	lto mo	121	2007	
State Registrar		31. Date filed (Month, Day, Year)	32 Registrar's Sign		alls?		-, , , , , ,			- %	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 3:57 2004 Kowink /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hopkins Bayvier Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) March 14,1913 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 90 217-07-3676 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "netural", or flems 23a or 28e-f show the Modical Examiner must be notified at MD N/A YYes 2 □ No Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 Imla STreet 21224 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 1 Tes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other then Machine Operator Tailoring or other treumatic event, permit. Pages 1 and 2 should be life Department of Health and Mental Hy Importent: If Item 27 is marked othe arty injury or other treumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Jankowiak Frances Yanka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Matilda J. Sobus (Sister) 420 Imla Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery 2/10/04 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 7 days hespiraton resulting in death) /Medical Due to (or as a consequence of): Examiner Preumoceocca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy should be detached for Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown How Frilus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayric-Johns Hocker 20 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 20 - sele Registrar

	_	1 - State Registra MEND ITEM #19a	PER INF G82	ryland / Dep 28 2/10/03Ce	artment of his	Health and Death		Reg. No. ZUL	14 0358	
Physicia /Medic Examin	cal	1. Decedent's Name (First, Middle, Last  Betty  4a. Facility Name (If not institution, give)  Fairh 3	street and number)	ines	-	SYKESYI	1110	Day Ye 31, 200	04 7:05 F	
Funeral Director		5. Social Security Number 6. Se 214-40-3196	3Z	93 Yrs.	Months Days	If Under 24 Hi Hours Mi		th ay, <i>Year</i> ) 9. 6, 1910 N	Birthplace (State or Fore Country) Maryland	
filled within 72 hours after death with the Maryland Hygiene. Ither than "natural", or flems 23a or 28a-1 show int, the Medical Examination ust be invitited at	ector	10a. State 10b. County  MD Carrol1  10e. Street and Number		10c. City, Town or L Sykesvi	.11e	-			10d. Inside City Lim 1 □ Yes 2 反 I	
eath with	Funeral Director	7200 Third Avenu	e C43	iver in II S 13	10f. Zip Code		(Specify Voc or No	U.S.A.		
72 hours after death with the Maryla "natural", or items 23a or 28a-1 show official Examinational be motified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2; ☐ N  If Yes, Give  Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		erto Rican, etc.)	s or No- ltc.)  14. Race - American Indian, Black, White, etc.  Specify: White		
within 72 h ene. than "natu be Modical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of w d)	rorking	16b. Kind of Business/Industry		
ed at a	To Be Co	17. Father's Name (First, Middle, Last)  Nesbitt Cox		5	ecretary		ame (First, Middle,	Educat Maiden Sumame)	ion	
od 2 is 27 is r trat		er, City or Town, State	e, <i>Zip Code)</i> land 21053							
Pages nent of ant: If ii		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		Dulaney	matory or other plac Valley	2/	Date 7 / 04		, Maryland	
permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens 23a. Part Enter the disease, or complete	986	64	4l5 Belai	r Road I	Baltimore	pel Funera , Marylan	al Home d 21206	
The law requires that the death certificate be executed with the death certificate be executed with the speed signed by the attending physician and be detached for use as the burial-transit carge 2 should be detached for use as the burial-transit.	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to (or a	consequence of):  consequence of):	Sepsis	5			Interval Between Onset and Death	
at the death certifica by the attending phi tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year	
w requires that been signed b should be dete	þ	Part II. Other significant conditions con	ntributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		e to the cause of death?  Probably 4 □Unkno	
	Completed						24a. Was autop perfor 1 □ Yes	sv prior t		
S : 5	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Many of Death  1 Natural 5 Pending investigation	lospital: 1	t 2 ER/Outpatier 28b. Time or 1 Injury	28c. Injun Work	er: 4 wursing	7	ne 6 □Other (S) low injury occurred	ресіту)	
	Certification;	3 Suicide 4 Homicide 6 Could not be determined	building, etc.				City or Tow			
To the Hosp within 24 ho To the Func completely fi	Medical	29a. Certifier   1  Certifying Physics (Check only one)   2  Medical Exeminates   20  Medical Ex	sician: To the best of ner: On the basis of e and manner state	examination and/or in	occurred at the time vestigation, in my op 29c. License	oinion, death occ	urred at the time, o	cause(s) and manner date and place, and d	ue to the cause(s)	
F 3 F 8		30. Name and address of person who co	moleted cause of des	ath (Item 23a) (Type	100	05994		-ebruary		
10	te	31. Date filed (Month, Day, Year)		Stoner	Ave. 5	ite 307	westr	ninster, M	10 21157	

		= State Amend Item 23a per Registrar	State of Maryl r Dr.,G828,02	land / Depa /09/04dab 	artment of H tificate of L	ealth and N Death	Mental Hy	giene Reg. No. 2	004	03529
Physic		1. Decedent's Name (First, Middle, Last)  JESSIE  L	JETER				2. Date of De. Month JANUAL		Year 2004	3. Time of Death $3: 07 A_{M}$
/Medi Examir		4a. Fecility Name (If not institution, give st	treet and number)	TER		Location of Death		4c. Count	y of Death	OORE
Funeral Director		5. Social Security Number 6. Sex 101-26-9921	7. Age (In	yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 6,	v Year)	9. Birth Con New	nplece (State or Foreign untry) 7 York
ryland		Usual Residence of Decedent  10a. State 10b. County		c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 \ No
the Ma r 28a-f s	Director	MD Anne Arun	nde1	Lin	thicum 10f. Zip Code			10g. Citizen of	What Co	
th with		561 Forest View Ro	ad			1090		United		
rs after dea	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:</li> </ol>	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (S in, Mexican, Puert Specify:	n? (Specify Yes or No- Puerto Rican, etc.)  14. Race - Black,  Specify:			ncan India <i>n</i> , e, etc. White
DESIGNMOTE, INIGITY INITIAL A. I. A. I. 3-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, if a Medical Examinating the notified at any price.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor f)	king	16b. Kind of E		
be filed watal Hygier of other the	Be	12 17. Father's Name (First, Middle, Last)	4	K	egistered	18. Mother's Nan Unknow				11.6
thould Mer market	2	Maynard Lilley  19a, Informant's Name/Relationship (Type	oe, Print)	19b. Mailie	ng Address (Street			er, City or Towr	n, State, 2	Zip Code)
nd 2 salth an 27 is		Robin Jeter Son	. ,	561	Forest Vi	ew Road,	Linthio	eum, MD	2109	90
Dallimore, bermit. Pages 1 ar Department of Hear mportant: if Item any injury or othe		20a. Method of Disposition  1. Burial 2 Cremation 3 Re  1. Donation 5 Other (Specify)	emoval from State	* * * * * * * * * * * * * * * * * * * *	osition (Name of matory or other place rematory,		Date 24-2004	20c. Location Baltin	,	
permit. I Departm Importal any inju		21. Sign turn of Funeral Service Licental	Shew 2	/ /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2. Name and Addre					f Lansdowne 21227
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the e cause on each line.		ter the mode of dyin			rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co	=						3 days
ate be executed hysicien and the burial-transit	ai Examiner	sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
od / ou	edlcai		l							
death cert e attending	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify) _	′		23d. Date of deliver		ivery Day Year
uires that the signed by the Id be detache	by	Part II. Other significent conditions con	ntributing to death but no	ot resulting in the u	underlying cause giv	en in Part I.		tobacco use co		the cause of death?
OT VICAL RECORDS  Physician: The law require this certificate has been siral director, page 2 should I	Completed						24a. Was auto perfo 1 ☐ Yes		were au prior to death?	utopsy findings available completion of cause of
VITAL IN ICIAN: The Ician: The Certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only			
ing Physician: After this certific uneral director,	ြင	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatre	of 28c. Injur	4   Nursing r	lome 5 Res	how injury occu		cify)
UIVISION O' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)		100 2		(Street and Nun wn, State)	nber or Ri	ural Route Number,
DIVISION To the Hospital or Attention 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exeminate)	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or in	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place	manner as e, and due	s stated. a to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	Med	iral Do	408 P-	se number 17785		29d. Date sign	ed (Mont	h, Day, Year)
		30. Name and addres person who co	mpleted cause of death	h (Item 23a) (Type HANOVL	for Print) ST	BALTI	MARE	mo	-2,	1225
S Regis	tate trar	31. Date filed (Month, Day, Year) FFB 0 9 2004	32. Registrar's	Signature						

			State of Maryland / Department of	Health and M	•	_	00500
			1 - State Registrar Certificate of		Reg. I	No.C U U 4	UUDUU
	Physic	an	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	/Medi Examir	cal	Doris     Mae     Jones       4a. Facility Name (If not institution, give street and number)     4b. City, Town,	, or Location of Death	Feb 6	2004 4c. County of Death	3:30aM
			Jpper Cheasapeake Medical Center     Bel.       5. Social Security Number     6. Sex     7. Age (In yrs. last birthday)     If Under 1 Yea		8. Date of Birth	Harford	
	Funeral Director		227-50-2833 1 M 2 F 64 Yrs. Months Days		July 13	ar) 9. Bring 1939 Vi	lace (State or Foreign stry) rqinia
	land wo		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		31=-		Od. Inside City Limits
	e Mary la-f eh	ctor	Md Harford Abingdon				1 ⊠Yes 2 □ No
	vith th	Director	10e. Street and Number 10f. Zip Code	)	10g. (	Citizen of What Cour	itry?
0	s 23s	E S	421 DeerHill Circle 210			U.S.A.	and the discountry
B	ter da	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of If Yes, specify Cu 1 □ Never Married  12. Was Decedent of If Yes, specify Cu 1 □ Yes 2 ☑ No	f Hispanic Origin? (Spec uban, Mexican, Puerto P	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
0336	altimore, Maryland 21215-0036 mit. Pagas 1 and 2 should be filed within 72 hours after daath with the Maryland partment of Haath and Mantal Hyglena. portant: if tiem 27 is marked other then "nature", or items 23a or 28a-1 show y injury or other traumatic event, the Madical Examinar must be notified at £2.	<u>م</u>	3 ⊠Widowed 4 □ Divorced If Yes, Give Year or Dates:	o Specify:		Specify: Bla	ck
	15-003 in 72 hours a "naturel", tedical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work down ille. DO NOT use retir	upation ne during most of workin ired)	16b.	Kind of Business/Ind	dustry
	212 d with glena.	mo.	Elementary/Secondary (0-12) College (1-4or 5+) Food Service			untry Cl	ub
,	be filed tal Hygla d other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
	aryland 2 should be filed and Mantal Hygle marked other umatic event, I	٥	Aubrey Rose Sr.	Gracie			
	Mar id 2 sho ith and ith and traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street				
2/6/04	Ore, M pas 1 and 2 of Haalth of Haalth of other tra		Regina Johnson/daughter 421 DeerH.  20a. Method of Disposition  15 Rugin 2 December 3 December 20b. Place of Disposition (Name of competery, crematory or other place)	lace) CITCI	e Abingo	CON , MD Location - City or To	21009 wn, State
3	Paga Paga ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify) ☐ KingMemorialPa:		,2004 Ba	alto.Md,	
a	Baltimore, N parmit. Pagas 1 and Dapartment of Haalth Important: If Item 27 eny injury or other tr once.		21. Signature of Funeral Service Diceasee	ress of Facility SCRUGGS PRESTON S	_FUNERA	L HOME	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	PRESTON S ying, such as cardiac or	respiratory arrest,	O.,MD 21	Approximate
	Priysician	s 5	Immediate Cause (Final disease or condition				Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				2 50116
a 110		ě	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	AIMON		1	C 1475
M)	cutad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events cause.			(	2 DAYS
0	8760, ate ba axecutad hysiclan and iha burial-transit	i Ex	resulting in death) Last Due to (or as a consequence of):				
39	687( tificate I tig physi as tha t	edicai	d				
3413	BOX 68 deeth certificat a attanding phy of for use as th	M/UR	IF FEMALE: 23b. Was decedent pregnant in the least 10 growths2  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy			23d. Date of deliver	y
#	. 0 0 2	Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown  1 Unknown  1 Unknown			Month	Day Year
1	Or ag d ag	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	iven in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
•	Cord	eted	DYSPHAGIA		1 Yes	2 No 3 Proba	ably 4 Unknown
1	has la	Completed	MUTIPLE CEREBLAL VASCULAR ACCI	SINENTS	24a. Was an autopsy performed?	prior to con death?	sy findings available inpletion of cause of
		BeC	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☑ N Check on one	le   1 □ Yes	2NO
5	of Vita Physician: rthis cartifici ral director,	ဥ	1 ☐ Yes 2) No Hospital: 1 A atient 2 ☐ ER/Outpatient 3 ☐ DOA			6 ☐Other (Specify,	
Joris	OD ding P. Aftar	tlon	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year) (Month, Day Year)  28b. Time of Injury Wo	uryat 28 ork? ∐Yes 2 ∐No	3d. Describe how inj	ury occurred	
(7)	Division of Vita Hospital or Attending Physician: 14 hours after death. Funeral Director: After this cardific taly filled in by the funeral director,	Certification;	2 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Bf. Location (Street a City or Town, Sta	and Number or Rural	Route Number,
ones,	Div oital or A urs aftar ral Direc		- Status of the (openity)				
10	To the Hospital Within 24 hours a To the Funeral Complataly filled	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the transfer on the basis of examination and/or investigation, in my and manner stated.	time, date and place, an opinion, death occurred	nd due to the cause( d at the time, date ar	s) and manner as sta nd place, and due to	ited. the cause(s)
	To th within To th	Me		nse number		ate signed (Month, D	
4	•		1 / 1 / 10 HS	55922 OPPER CHE	FER	SRUARY 6	2004
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOO HNTHONY W SAMPHUPO DO. BELL	CAIR, MI	21019	4	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	FEB 0 9 2004 Re M. Aparle				

N		For 1_ State	State of Maryland		ent of Health and Nate of Death		ne 2004	03531
		Registrar  1. Decedent's Name (First, Middle, Las.	1)		THE OF BOALT	2. Date of Death		3. Time of Death
Phys /Me	ician dical	Robin Ann	Kroll.			February		1434 P M
	niner	4a. Facility Name (If not institution, give 7421 Bay Front Roa			ty, Town, or Location of Death dgemere	1	4c. County of Death Baltimore	
Funer	al	5. Social Security Number 6. Se			der 1 Year   If Under 24 Hrs.	(Month, Day, )	(ear) 9. Birthp	lace (State or Foreign try)
Directo	or	Usual Residence of Decedent	4 7/1			11-2-4		/
larylan ebow	ō	10a. State 10b. County	more 10c. City,	Town or Location	c. C 0			0d. Inside City Limits 1 ☐ Yes 2 No
h the N or 28a-f	lrect	10e. Street and Number	more	101.	Zip Code	100	p. Citizen of What Coun	try?
sath wil	Funeral Director	7421 Bay Fr	12. Was Decedent Ever in U.S.	13. Was De	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
be filed within 72 hours after death with the Maryland tala hygiene. It als hygiene. It is maintain, or items 23s or 28s-f show word, the Maryland Examinar must be multiped.	V Fund	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give (		pecify Cuban, Mexican, Puert 2 No Specify:	o Rican, etc.)	Specify:	etc.
2 hours	ted by	3 Widowed 4 □ Divorced  15. Decedent's Ed		16a. Decedent's U	sual Occupation work done during most of wor	tking 10	Sb. Kind of Business/Inc	dustry
be filed within 72 Ital Hygiene. Id other than "naiseenent, the Mindle	Completed	(Specify only highest gra	College (1-4or 5+)	life. DO NO	T use retired)	A. I. I	at hope	4
filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)		noncer		ne (First, Middle, Mi	aiden Sumame)	
Lai y lailly 2.12. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Man	To B		05.		Jean	Kams	burg	
2 2 2 2		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Add	ess (Street and Number or Ru	d. A. VI	City or Town, State, Zip	72X )
Dattillioi C, Mary to permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic.	1	20a. Method of Disposition	20b. Pla	ce of Disposition ( netgry_crematory	Name of	Date 2	oc. Location · City or To	own, State
Darrillo permit. Pages Department of I Important: If Its		1 Burial 2 Cremation 3 -  1 Donation 5 Other (Specifi		SFUNERAL	CHAPEL - 2-	10 -04 F	OREST HI	u, mo
Dermit Depar Impor	OUCE	21. Signature of Funeral Service Licen	Bull other	EVAN.	and Address of Facility 3 A	APT6-BE	LAIR P.A.	
100		23a. Part1. Enter the disease in the mishock, or heart failure. Let only	olic rtions that caused the death.	Do not enter the	node of dying, such as cardia	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death)	a. Smoke and Due to (or as a conseque		ndation			
Examin	20.00	Sequentially list conditions.	b					
ted	Fxaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):			\	
e executant and and unial-tra	F		Due to (or as a conseque	ence of):				
DX OC/OU, Certificate be executed ading physician and se as the burial-transit	i d		d					
EOX OB/OU, eath certificate be executed attending physician and for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan	death 3□Ectop	cpregnancy		23d. Date of delive Month	ery Day Year
that the death led by the atterded for u	Phyeir	1 0 Vee 0 0 No	4∏Pregnant at time of dea 9☐Unknown	ath 5 ☐ Othe	(specify)			
0 8 6 g	2		contributing to death but not resul	ting in the underlyi	ng cause given in Part I.	23e. Did tob	acco usa contributa to t s 2 DXÑo 3 ☐ Prot	he cause of death?
requi	0					24a. Was an	24b. Were auto	ppsy findings available
The law						autopsy perform Yes 2	ed? death?	mpletion of cause of
OT VITAL P Physician: Th this certificate	5 6	25. Was case referred to medical examiner?	Hospital:		Other	ath (Check only one	nce 6 XOther (Specia	At gone
Phys this		- 2263	1   Inpatient 2   E	ER/Outpatient 3[ 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		WAC SCEILE
VISION ( r Attending I er death. rector: After		1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	1 Chruay 5, 2004	2:10 PM	1 ☐ Yes 2 🕅 No		use the	al Route Number
DIVISION  of or Attending  stater death.  I Director: After	9	27. Manner of Death  1		me, rarm, street, ra	ctory, office	City or Town		mere MA
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director. After	iery min	29a. Certifier 1 Certifying Pl	hysician: To the best of my know miner: On the basis of examinati	viedne death occu	rred at the time, date and plac tion, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as s te and place, and due t	stated.
thin 2 cthe		29b. Signature and title of certifier	and manner stated.		29c. License number	29	d. Date signed (Month,	Day, Year)
<b>⊢</b> ≶⊢ 8	5	Lougha A	Thee speno	MA	O.C.M.E.	1	February 06	, 2004
5		30. Name and address of perso, who	completed cause of death (Item	1 1		7.		201
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signat		enn Street, Ba	itimore, l	maryland 21	_ZU1
Reg	gistra		2004	A	Ana W.			-

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 0 1 L

3								
20	0	4	0	3	5	3	2	

			1 - State Registrar AMEND ITE	M #4c PER ME G82	28 2/09/04	Ge	rtificate of	Death			g. No.	2.004	0333	1
В	Physici	an	Decedent's Name (First, Middle, Last)     Month						2. Date of Deat Month	h Day	Yeer	3. Time of Death		
	/Medic			Susan Krea						Februar			8:32 A	M
	Examin	er	4a. Facility Name (If not instituti	on, give street and number	)		4b. City, Town, o	r Location o	of Deeth			County of Deeth		
		-	554 Jeffrey F 5. Social Security Number		ge (In yrs. last b	inthday)	Millers If Under 1 Year		24 Hrs.	S. 8 Date of Birth				
70	Funeral Director		217-74-1742 Usual Residence of Decedent	1□M 2X F	44	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, June 2,	Year) 195	9 Ma	place (Stete or Foreigntry) aryland	<i>p</i> :
9600-61713	anyland show	ž	10a. State 10b. Coun	ty	10c. City, To	wn or Lo						1	10d. Inside City Limit	
	he M	Director	Maryland Anne Arundel Millersville  10e. Street and Number 10f. Zip Code 10g							0 - Citi-	en of What Cour		_	
	with	ā										•		
	eath	eral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.1			gin? (Spec	cify Yes or No-	_	ted Stat		_
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Rema 23a or 28a-f show aumatic event, the Madical Evanthar must be notified at	by Funeral	1 ☐ Never Married 2 🔯 Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Forces	? <b>(</b> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 【X No Specify:						Black, White, etc.  Specify: White		
	2 hou	ted	15. Decede	ent's Education	ntion 16a. Deced			dent's Usual Occupation				6b. Kind of Business/Industry		
	within 7, iene. than "n	Completed	Elementary/Secondary (0-12)	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  11th			kind of work done of DO NOT use retired	,	t of workin	Gra	Grocery Store			
2	Hilled Hyg other ent,	Be C	17. Father's Name (First, Middle	e, Last)			orer orer		r's Name	(First, Middle, M			LOIC	
≥ ``	lid be fental rked ric ev	To B	Morris Edwar	rd Thomas				Bett	у	Mc	Ginn:	innis		
	should by and by		19a. Informant's Name/Relation	nship (Type, Print)	19	b. Mailir	ng Address (Street	and Numbe	r or Rural	Route Number	City or	Town, State, Zip	Code)	
	l and lealth om 27		David Wayne K:	reamer	20b. Place	of Dispo	Telegrapt sition (Name of natory or other place					n Mary ation - City or To	Land 2114 own, State	4
	Pages ment of P ant: If ite ury or o		' 4 □ Donation 5 □ Other		West A		del Crema							
	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A.  1411 Appapolis Road Odenton Maryland 21113											
	547		23a. Par). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  M00957 1411 Annapolis Road Odenton, Maryland 21113  Approximate Interval Between											
	Physician		Immediete Cause (Final	Λ 1									Onset and Death	
	/Medical		disease or condition resulting in death)	a. HSphi Due to (or a:	s a consequence	of):			•					_
	Examiner		Sequentially list conditions b.											
	D ==	Examiner	f any, leading to immediate  Due to (or as a consequence of): cause. Enter Underlying											
	tificate be executed og physician and as the burial-transit	cam	Cause (Disease or injury that initiated events c											
Š	be ex cian burial	al E												
00/00	physi	Aedical		d										
<b>y</b>	ding	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy						22	2d. Data of dollars		
	he death	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 20 Unknown	1 ☐ Live birth	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery  Month Day Year		
_	that sed by deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tob	tobacco use contribute to the cause of death?			
ָה מ	quires n sigr ald be	d by		1 ☐ Yes							s 2 🔀	2 No 3 Probably 4 Unknown		
2	w rec	Completed								24a. Was ar	1	24b. Were auto	psy findings available	е
ב	he la	omp								autops	red?	death?	inpletion of cause of	
g	tifical	e	25. Was case referred to medic	cal				26 Place	of Death	(Check only one		1 Yes	2□ No	
>	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To B	examiner? 1 <b>XX</b> es 2□ No	Hospital:	ient 2 ER/O	utpatien	t 3 DOA Othi	or				6 Nother (Specify) At scene		
DIVISION												injury occurred		
		atlo	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation February 2 2009				M 1 Yes 2 No Subject				nas stangled			
	r Atte	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☑-Homicide dete	njury - At home, t	ry - At home farm street factory office 28t Location (5					Street and Number or Rural Route Number, vn. State)				
	ital o irs aff ral Di	Cer	home 554 Jett						fre	rey Rd, Millersville, MD				
	he Hosp n 24 hou he Fune pletely fil	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To t To t	Ž	29b. Signature and title of certifier									Date signed (Month, Day, Year)		
	Ň								ebru	bruary 3, 2004				
	4		30. Name and address of person			(Туре,	Print)							
					1.D		111 Per	nn Str	reet,	Baltim	ore,	Maryla	nd 21201	
	Sta	7.7	31. Date filed (Month, Day, Yea	AN ARM ROOM TO THE BELLEVISION OF THE PROPERTY.	trar's <b>Sig</b> nature		F	and the same of th						

Registrar

**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. It has a 12 is marked other than "natural", or items 23a or 28a-1 ahow other traumatic event, "Le Modical Examinar mat be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should nent of Health and Men

permit. Pages 1 and 2 to Department of Health ar Importent: If Itam 27 is eny injury or other traugonce.

Physician

/Medical

Examiner

burial-tran

the attending ph

physician

Š signed b

certificate has birector, page 2 s

₽ this After thi

The law requires that the death certificate be executed

Box 68760

P.O. I

Division of Vital Records,

or Attanding Physician:

death. I Director: A

hours after within 24 hours and To the Funeral Dir

To the Hospitel

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 03533 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February Day 5, **Physician** 1441 P M 2004 Kroll Richard Evan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Edgemere Baltimore 7421 Bay Front Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/14/1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1**X** M 2□ F Yrs. 47 Maryland 215-68-4797 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c City Town or Location 1 ☐ Yes 2 X No Director Edgemere Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 S. Α. 7421 Bay Front Road Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Bethlehem Steel Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maccubbin Catherine Lorraine Kroll ပ Henry John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Middle River, Maryland 21220 Sharyn Lee Trent 1122 Sterhen Drive (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition /10 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee <sup>22.</sup> Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition soot inhabation and Smoke resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ es 2 □ No 24a. Was an autopsy performed 1⊠Yes 2□No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dether (Specify) On scene 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending Injury house tire PM 1 Yes 2 No Ebylauf 5, 2004 | 3 ! 10 PM | 1 = 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Edgemen 4 Homicide 7421 Bayfront Rd ome Certifying Physician: To the best of my knowledge death conumed at the time, date and class, and due to the cause(a) and manner as stated 25a. Certifica Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ker O.C.M.E. February 06, 2004 who completed cause of death (Item 23a) (Type, Print)

State Registrar lasha Z Gireenberz

31. Date filed (Month, Day, Year)

FFB 0 9 2004

DHMH 17 Rev 1/2001

**ORIGINAL** 

111 Penn Street, Baltimore, Maryland 21201

M.D

32 Begistrar's Signature

			1 - For Amend Item 10f per State Registrar	State of Maryland FH,G828,02/09/0	/ Depa /dhb <i>Cer</i>	artment tificate	of H	ealth a Death			Heg. No.	004	03534	
	Physicia /Medic Examin	an	Moni							2. Date of De Month	Dav Year			
A His			RUBERT N. KARIMAN FEB. 2 2004								10.1-0			
à	Funeral Director		5. Social Security Number $218-10-8994$ 6. Sex $1 \overline{\chi}$	M 2□F 7. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da EB 18	th ly, Year) 1919	9. Birth Cou	place (State or Foreign ntry)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exertifier must be notified at once.	or	Usual Residence of Decedent           10a. State         10b. County           MD         BALTIMORE		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
		i Direct	10e. Street and Number 9050 IRON HORSE LAN		11100 1	10f. Zip	Code 117	2120	08		10g. Citizen of USA	What Cou	ntry?	
036		by Funera		2. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:			ent of His	spanic Origin, Mexican	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	- 14. Rac Bla	ce - Americk, White,		
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  WHOLESALER  16b. Kind of Business/Industry (CANDY & TOBACCO									,		
Maryland ?		To Be C	17. Father's Name (First, Middle, Last) I SADORE	KA	NRTMAN	l		18. Mother		(First, Middle,	Maiden Sumar COHEN	ле)		
			19a. Informant's Name/Relationship ( <i>Typ</i> MRS.SHELLEY SARSFIE			_					er, City or Town IINGS MI		D. 21117	
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	ce of Dispon netery, crem IMORE	natory or ot	her place		<sub>ام</sub> 5/20/	004	20c. Location REISTER			
Balt			21. Signature of Funeral Service License	ml							ON & BR ESVILLE			
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and positive completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  The Control of the Con											
8			PAG											
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):											
68760,		edical	<b>L</b> d.											
O. Box		Physician/Medical	IFFMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year			
rds, P.		by								obacco use con Yes 2 2 No	pacco use contribute to the cause of death?			
Vital Records,		Completed								1 Yes	osy rmed2 2 No	prior to co death?	opsy findings available impletion of cause of	
Division of Vita		To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1   Inpatient 2   XER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)										
			27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	To inpatient 22 Acrivodipation 30 DOA 40 Huising Hon					28d. Describe how injury occurred					
Divis		Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		edical	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
•		Σ	29b. Signature and title of certifler	May			License	0 1	f ?		29d. Date signe	d (Month,		
	81		30. Name and address of a on cor	158 40.	(Type, I	Print)	1	1116	2166	7 40	12/	ext	1	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re e	B	Aug.	K		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ALEXANDER MOJCIEK KITMECKT 27, 9:33 P M Januarv 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. April 8, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F Poland 101-26-4533 83 1920 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itema 23a or 28a-f ahow the Mudical Examiner must be notified at 1 Yes 2 No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 U.S.A death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Manufacturing Company and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wladyslaw Klimecki Helena 2 Lucka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Michele H. Vandover 10406 Cold Harbor Drive, Hagerstown, Md. 21740 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematorium 01-29-04 Smithsburg, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 R. hoel Brad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Fracture left femur resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ pneumonia, ischemic bowel, ASCVD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No this 28d. Describe how injury occurred fall at 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 XNo 01-08-04 3:30 p<sup>M</sup> investigation 2 X Accident Fahrney Keedy Nursing Home 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Fahrney Keedy Nursing Home completely filled in by 4 Homicide 8507 Mapleville Rd. Boonsboro, within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0011266 January 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N. Weeks, MD 580 Northern Avenue, Hagerstown, Md. 21742 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Physician JUANITA 10:30AM HEMON 20 700H /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOLY CROSS NURSING AND REHABILITION HOME BURTONSVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth
(Month, Day, Year)
JAN. 11,1915 Birthplece (State or Foreign Country) **Funeral** Days Hours Months 1□ M 21 F 517-38-6623 89 **TEXAS** Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mantal Hygiena. Important: If item 27 is marked other than "natural" any injury or other traumatic excellent. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD MONTGOMERY BURTONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3415 GREENCASTLE RD. 20866 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates: Specify: Be Completed by 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWNED HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRED W. SPARWASSER BERTHA T. WEBSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) LAWRENCE LEMONT/SON 12807 SILVERBIRCH LN. LAUREL, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 2-01-04 LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) BALT, -- WASH. - CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME, INC. Sti Wart anna 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) BREAST CANCER 1 YEAR Examiner Due to (or es e consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate by executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asserts. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) esn jo signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown DEMENTIA Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? certificate has b lirector, paga 2 s 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 42 Nursing Home 5 Residence 6 Other (Specify) ၉ this : After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Netural 2 Accident 5 Pending investigation i Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) after 4 ☐ Homicide within 24 hours af To the Funeral Di complataly fillad in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. edical 29a. Certifier To the 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signetate end title of certifier D43237 JANUARY 20, 2004 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 14201 LAUREL PARK DR. # 102 LAUREL, MD 20707 PAUL ARMSTRONG, M.D.

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

FFR 0.9 2004

32. Registrar's Signature

			For	State of Maryland	d / Departme	ent of Heal	ith and Me		T 1	04	03537
			Registrar Amend Item 2  1. Decedent's Name (First, Middle, L	perPHYG828 2/17/04 F	W Certifica	ate of Dea	atn  -	2. Date of Deat Month	ig. No.	2/.	3. Time of Death
	Physicia /Medic	an	Mary	Ellen Line	J.			Month FCD	Day 4 ZON	Year /	2:00 A.M
	Examin		4a. Facility Name (If not institution, g	ive street and number)	4b. C	TOWN, or Loca			4c. County	of Death TIN	MOE
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yes, la	ast birthday) If Un Mont	ider 1 Year   If L		B. Date of Birth (Month, Day,			e (State or Foreign
. t <sub>a</sub> .	Director		310 - 10 - 4387	1□M 20F	7. Yrs. Monte	hs Days Ho	ours Min.	12-27	7-16	Ind	iana.
	Maryland -f show livi at		10a. State 10b. County	10c. City	, Town or Location	,	1			10d	. Inside City Limits
-		ector	MD HAR	FORD	FORE		+111		0- 04	That Causta	1 □ Yes 2 No
33	death with the ma 23a or 28a	Dire	212 Cartle	and Wail	10f.	Zip Code	(50)	"	0g. Citizen of W	) SA	14
25	itema 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was De	ecedent of Hispan specify Cuban, Me		ify Yes or No- ican, etc.)		- American k, White, etc	
36	hours after tural', or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	s 20 No Sp	ресіту:		Specify:	whi	te.
500	72 hours "natural",	eted	15. Decedent's (Specify only highest of	Education grade completed)	16a. Decedent's U (Give kind of	work done during	g most of workin	g	16b. Kind of Bu	siness/Indus	stry
22	within 72 iene. than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Optice	Tuse retired)	rinoed	5	ROF	7	
عرر	al Hygi d other	Be C	17. Father's Name (First, Middle, La	st)		18/	Mother's Name	(First, Middle, A	Maiden Surname	a)	_
Maryland 212	2 should be filed and Mental Hygi is marked other aumatic event, I	2	19a. Informant's Name/Relationship	Dh Wida	19b. Mailing Addr	ress (Street and I	CLED 1	RANCE Boute Number	City or Town	State Zip C	JUE_
			KOREN L. BRU	WER.	212 Car	toud 6	chy Fo	rast F	till m	Dai	050.
ore,	of He Hitem		20a Method of Disposition 1 Burial 2 Cremation 3	Removal from State	lace of Disposition (		Da	ite	20c. Location -	City or Town	n, Slate
A. Amy Baltimore,	Pa Int		<ul> <li>4 □ Donation 5 □ Other (Special Service Licenses)</li> <li>21. Signature of Funeral Service Licenses</li> </ul>	city) EVAI	NS FUNER	ALCHAP	Facility - 1	P = 04	FORES H	THIC	mond
≥ Ba	permit. Deportri Importa any inju		Kimberly	a. Zowotry	EVAN	SPUND	KALLHH	PELTO	ELAIR		21050.
180	1		23a. Part1. Enter the disease, of coshock, or heart failure. List on	mplications that saused the death ly one sause on each line.	n. Do not enter the n	node of dying, su	ch as cardiac or	respiratory arre	est,	A	pproximate iterval Between inset and Death
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Badey I	2emon	ara			4	TENS
- 8	Examiner		Compagning the line and divine	Due to (or as a consequ	rence or).					13	
	ed sit	lner	S - uential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	aerice of):						
1	ba executed icien and burial-transi	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
976	6 0 0	cal		d							
9 × 6	leath certificate- attending physi I for use as the I	/Wec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy				23d, Date	e of delivery	
. Bo	death	Physician/Medl	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		c pregnancy (specify)			Mor		
Division of Vital Records, P.O. Box 68	w requires that the de been signed by the s should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions		ulting in the underlyir	no cause given in	Part I.	23e. Did tob	acco use confr	ibute to the	cause of death?
rds,	quires an sign uld be	ed by						1 □ Ye	s 2 24No	3 Probab	ly 4 Unknown
eco	law renas bee	Completed						24a. Was ar autops	y   p	rior to comp	y findings available letion of cause of
a B	sician: The lav certificate has rector, page 2		O5 West and entered to medical					1 SZ Yes 2	2 □ No 1	eath?	RINO
r Vit	ysicia iis certi directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3	Other	Place of Death		5 10 75 75	or (Specify)	tospice
o uo	i or Attending Physafter death. Director: After this in by the funeral di		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes		3d. Describe ho	w injury occurre	ed .	
/isic	Attendir death.	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	t be 28e. Place of Injury - At ho	ome, farm, street, fac				reet and Numbe	or or Rural R	loute Number,
ā	ital or irs afte ral Dire		4   Homicae	building, etc. (Specify	7 ====================================			City or Town	., State)		
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical		Physician: To the best of my know manner: On the basis of examinat and manner stated.							
	To the within To the	Me	29b. Signature and fittle of certifier	1 112		29c. License nur	mber	29	9d. Date signed	(Month, Da	y, Year)
			Mar	~~~~	20.15	V 58	503	_   F	devan	140	2004
	10		30. Name and address of person with Acrom J. Charles	completed cause of death (Item	23a) (Type, Print)	arlas	St Bon	Church	e mi	1212	04
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	/					
DH	Regist	_	FEB 0.5	2004 Samue	~ M	Sports					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla		tment of Health and M ificate of Death	Mental Hygie Reg.	70114	03538
	Physici	an	1. Decedent's Name (First, Middle, Las	orraine	Latti	uore.		Day Year	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death		4c. County of Deeth	
	Funeral Director		219-25	ex 7. Age (In yrs	s. last birthday) 69 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	and	or	Usuel Residence of Decedent  10a. State 10b. County	1A 10c. C	City, Town or Loc	saltimore	*		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	s with the h	Funeral Director	100. Street and Number 1015 N. Kenwood	1 Ave.		10f. Zip Code 2/205	10g.	Citizen of What Cou	ntry?
036	thin 72 hours after death with the Maryland e. An "natural", or Hems 23a or 28e-f ehow Medical Examiner must be notified at	by	11. Marital Status  1 □ Newer Married 2 □ Married 3 ₺ Widowed 4 □ Divorced	12. Was Decedent Ever In Armed Forces? 1 Yes 2 Violo If Yes, Give Year or Dates:	lf lf	Las Decedent of Hispanic Origin? (St Yes, specify Cuban, Mexican, Puerto Yes 2 TNo Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ameri Black, White Specify: Black	
	a 1 10	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th Grade		(Give k	int's Usual Occupation and of work done during most of work ONOT use retired)		Sreybar	Electric Co.
Maryland (	uld be file Vental Hyg trked othe	To Be C	17. Father's Name (First, Middle, Last) ASDWN Robin				me (First, Middle, Main Mice Wi		
, Mary	and 2 sho saith and I n 27 is ma		19a. Informant's Name/Relationship (	imore-daught	4 1015	Address (Street and Number or Au N. Kenwood f	tve. Bal	Himore, N	laryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: If item 27 is marked other than eary injury or other traumatic event, the Magnee.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specification 2). Signature of Funarial Service Licenters	Removal from State	arrison	atory or other place)	11 1 1 1	E. Location - City or T Wings Mil	ils, Maryland
Ba	Deper Impo		> ferin f	arker	35	72 Frederick A		nove, Mai	yland 21229
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	A Jene equence of):	carcinoma	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dlcal E		_ d					
.O. Box 68	at the death certifica by the attending phateched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3 🗔	Ectopic pregnancy Other (specify)	1,000	23d. Date of deliv	very Day Year
Δ.	quires that t n signed by Ild be deta	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to	
Vital Records,	: The law requires that cate has been signed b page 2 should be deta	Completed					24a. Was an autopsy performed	d? death?	opsy findings available ompletion of cause of 2 □ No
	Physician: T this certificat al director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	Other	th (Check only one)	e 6 ∏Other (Spec	ifv)
ion of	fter	-	27. Mann of Death  1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	-	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i		<i>"</i>
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, stre cify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
X	Mospi 24 hour Funerately fills	adical (				occurred at the time, date and place estigation, in my opinion, death occu			
	To the within To the complete	Z	29b. Signature and title of certifier	D	0.06	29c. License number	29d.	Date signed (Month,	Day, Year)
	17		Mullita	susta, 1	(4)	P16485		01/31	12004
			30. Name and address of person who	completed cause of death (It	1 St. t	avil Place B	altimore	. Maryla	nd allos
	Sta Regist		FER 0 9 20	104 Areas	M As	all .			

	· ·		1- For State Amend Items 24a	State of N ,25,26,27,2	Maryland / Dep 9a,30per Dr.Ce	artmen 3828-02 rtificati	1/85/H	ealth ar Adhb Death	nd Mer	ntal Hyg	iene <sub>eg. No.</sub> 20	04	0353	(
	Physici /Medi		1. Decedent's Name (First, Middle, Las Judith LaChance						2.	Date of Deat		rear 4	3. Time of Death	м
	Examir		4a. Facility Name (If not institution, give Holy Cross Hospi	tal	r)	Silv	er S	Location of t	Death		4c. County of	f Death	V	
×4	Funeral Director		5. Social Security Number 6. Security 110-28-0107	X 7. A	Age (In yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, an 30,	Year)	9. Birth Cou	place (State or Foreig intry) York	ZΠ
	Maryland a-f show	tor	10a. State 10b. County MD Montgome:	:y	10c. City, Town or Lo Silver Sp								10d. Inside City Limit:	
	th with the 23a or 28a	al Director	10e. Street and Number 8600 16th Street	#1007		10f. Zip	Code 20910	)		1	0g. Citizen of Wh	at Cou	intry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If Item 27 te marked other than "naturel", or Iteme 23a or 28a-f show any injury or other traumatic event, If a Medical Erain for ministic traumatic event, If a Medical Erain for ministic to indiffer all pages.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes  X If Yes, Give Year or Dates	] No	Was Deced If Yes, spec		spanic Origin , Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race -	White,		
21215-0036	within 72 ho iene. then "natur te Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	cation de completed) College (1-4or 4	(Give	DO NOT us	rk doné di	uring most of	f working		16b. Kind of Busin			-
Maryland 2	should be filed and Mental Hygia marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Harry Solon	·				18. Mother's		rst, Middle, M Veisma:	Maiden Surname)	-		
Man	d 2 sho		19a. Informant's Name/Relationship (7) Ronald Johnson/sp	*							City or Town, St			
Baltimore,	Pages 1 and nent of Health int: If Item 27 ary or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	20b. Place of Dispo	sition (Nam	ne of		Date	-	r Spring 20c. Location - Ci	_		
Balti	permit. Departn Importe any inju		21. Signal are of Funers Service Licens	Nade, Vi	St Ba	Trino	nato re,	my Boa MD 21	- 201		Baltimor	re S	Street	
8760,	Physician and // Medical Examiner the prival-Itansit sthe prival-Itansit	al Examiner	23a. Part Enter the disease, or comp shock or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. cirrh Due to (or a Due to (or a hepat	osis of liv s a consequence of):	er wi	th p						Approximate Interval Between Onset and Death	
.O. Box 687	ne death certifii the attending f thed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown		2 Fetal death 3	Ectopic pre					23d. Date o		ery Day Year	
Ω.	w requires that the bean signed by should be detact	ed by Pr	Part II. Other significant conditions co	ntributing to death	but not resulting in the u	nderlying ca	iuse giver	n in Part I.					he cause of death?	1
Vital Records,		Completed							_	24a. Was ar autopsy perform 1∐ Yes 2	/ l prio	or to cou	ppsy findings available mpletion of cause of	•
<u>=</u>	ysicien: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 X No	Hospital: 1 🔀 Inpat	ient 2 ER/Outpatien	t 3 DO	Other			eck only one	nce 6 Other	(Canail		
Division of	F = 18	Certification; T	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Inj (Month, D			3c. Injury	at	28d.		w injury occurred	Specify	v)	
Ω	Hospitel or Attending 24 hours after death. Funeral Director: After tely filled in by the funer		3 Suicide 6 Could not be determined	building, e	njury - At home, farm, str etc. <i>(Specify)</i>					City or Town,	,			
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in I	Medical	29a. Certifier (Check only one)  1	sicien: To the besiner: On the basis and manner s	t of my knowledge, death of examination and/or in- tated.	estigation,	it the time in my opi	nion, death o	place, and o occurred a	the time, da	use(s) and manne te and place, and d. Date signed (A	d due to	the cause(s)	
	⊢ 3 ⊢ ŏ			Jaya		.   1	0-005				anuary 2		6200	_
			Paytel Jayanti,			,	orest	Glen F	kwy.,	Mary1an	ıd			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 9 200	30 Regist	trar's Signature	rade)								

			1 - For State Registrar	State of Mar		epartmer Certificat			nd M		iene 2	004	03540
	Physici		1. Decedent's Name (First, Middle, Last)  JOHN HEN		.OWMAN	JR.				2. Date of Deat Month Februa	Day	Year 4 . 212121	3. Time of Death
X	/Medio		4a. Facility Name (If not institution, give sharing Joseph	street and number) Medical	Cente			Location of	Death OWS	on	4c. Cou	inty of Death	timore
ľ	Funeral Director		5. Social Security Number 6. Sex 218 - 24 - 1629	M 2DF	'In yrs. last birth	Months Months	Days	Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, June 28	, 1929	Cou	place (State or Foreign htry) ryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination man be invitibled at once.	Completed by Funeral Director	10a. State 10b. County Maryland Washi  10e. Street and Number 7 East Washingt	ngton	et	erstow 10f.Zip	Code 2174		n? (Spec		U . S	of What Could Bace - America	can Indian,
-0036	hours after fural', or the	ed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ	1 ☐ Yes 2X☐ No If Yes, Give Year or Dates:	162 (	1 🗆 Yes	2[XNo	Specify:			Spe		ite
21215-0036	d within 72 giene. er than "na'	complete	(Specify only highest grade	College (1-4or 5+)	164. [	Decedent's Usua 'Give kind of wo life. DO NOT u Labor		tion uring most o	of working			f Business/In orial	Service
Maryland	2 should be file 1 and Menta! Hy 18 marked oth raumatic event	To Be (	17. Father's Name <i>(First, Middle, Last)</i> John Heni		wman	Jr.		Ire	ne		zabet	:h	Gross
	and 2 shueaith and m 27 is m		19a. Informant's Name/Relationship (Ty) Penelope A. Marks	Sister	7	23 Mary	land		Je, ⊦	Route Number, lagersto	own, M	ld. 21	740
altimore,	Pages 1 Iment of H tant: If ite jury or ot		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		cemetery	Disposition (Nar , crematory or o ill Cem	etery	y C	Da 02-10	0-04 H	lagers		Maryland
Bal	Departit Import any in		21. Signature of Funeral Service License R. holl f	Brady		Andrew 40 Eas	K. (	s of Facility Coffma tietam	an Fu 1 St.	uneral H .,Hagers	lome, stown,	Inc. Mary	land 21740
	Inysician /Medical Examiner	87 1	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	Myocar	dial I	e or aying	, such as ca	ardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
8760,	certificate be executed thing physician and tse as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate as a second of the conditions of the condit	Due to (or as a d									
ğ.	death e atter d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of 1 □ Live birth 2 ( 4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp						Date of delive	ory Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions con	tributing to death but r	not resulting in t	he underlying c	ause givei	n in Part I.		23e. Did toba	5.7		ably 4 \(\bigcap\)Unknown
ř	The ate h	Completed								24a. Was an autopsy perform		prior to cor death?	psy findings available npletion of cause of
Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 ER/Outp	atient 3 DC	Other			Check only one			
	pe je		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. D. te of Injury (Month, Day Y	28b. Tin		8c. Injury Work?	4   INUIS	28	e 5 🗌 Resider d. Describe how			()
Division	tal or Attendir rs after death. al Director: Al ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farn Specify)	n, street, factory	, office		28	f. Location (Stre City or Town,	et and Nur State)	mber or Rura	l Route Number,
:	To the Hospital or J within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of r er: On the basis of ex and manner stated	amination and/	death occurred or investigation,	at the time in my opi	o, date and p nion, death	occurred	d due to the cau I at the time, da	use(s) and i	manner as st. e, and due to	ated. the cause(s)
	To T	Σ	29b. Signature and title of certifier	6. Mule	^	29c	License	number 242		29	d. Date sign	ned (Month, 1 05/04	Day, Year)
	7		30. Name and address of person who cor				_Tow	son.	Mar	vland	21,07	145.	
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's 9 2504	Signature	K	Land	2				-	

For State Registra

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

Social Security Number

Usual Residence of Decedent

10a. State

Director

MARYLAND

8820

10e. Street and Number

151.01.7512

4a. Facility Name (If not institution, give street and number)

10b. County

WALTHER

SQUARE

1 XM 2 □ F

BLVD

6. Sex

BALTIMORE

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ttems 23a or 28e-1 show amy injury or other traumatic event, the Medical Examiner and by mutified at once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced IIWW 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS ECTRICAL ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MCMILLAN WILLIAM ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMMA E. McMILLAN VD. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
GARRISON FOREST
VETERANS COMETERY 1 Surial 2 ☐ Cremation 3 ☐ Removal from State FEB.11,2004 4 ☐ Donation 5 ☐ Other (Specify) TERANS GARRISON 22. Name and Address of acility EVANS 21. Signature of Funeral Service Licensee FUNERAL 8800 HARFORD RD &UMOL 23a. Part1. Enter the dileas i, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Die to (or as a consequence of): ney MoniA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last FUSUFF Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed NemiA and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Tes 2 No 3 Probably 4 Unknown peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 1 Tes 2 12 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this the funeral Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) nature and titl 29b. Sig/ 29d. Date signed (Month, Day, Year) 2 ddress of person who completed cause of death (Item 23a) (Type/ QUAKE DR. BAITIMORE Md 21237 McDowell FRANK 9000 Kennet H 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

OOTH

HOSDILA

7. Age (In yrs. last birthday)

0

10c. City, Town or Location

PARKVILLE

Certificate of Death

MILLAN

4b. City, Town, or Location of Death

Days

2123

Months

10f. Zip Code

If Under

Hours

24 Hrs.

Min.

Reg. No.

200

MORE

PONSYLVANIA

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 2 No

Year

4c. County of Death

10g. Citizen of What Country?

2. Date of Death Month

DHMH 17 Rev 1/2001

Registrar

FEB 0 9 2004

•		1 - For State Registrar	State of	Maryland / I	Departr <i>Certifi</i>	nent of H	ealth ar Death	nd Mental Hy	giene Reg. No.	2004	03542
		1. Decedent's Name (First, Middle, L.	ast)					2. Date of De			3. Time of Death
Phys		Russell A. Halsi	. Sr.					Februa	Day		
/Me Exar	dica	1		per)	4b	City, Town, or	Location of I			2004 County of Death	7:37 A M
* Exam	mnei	7959 Telegraph Ro				Severn	Location of	DOG!!!		-	
Former	21			Age (In yrs, last bii		Under 1 Year	If Under 24	Hrs. 8. Date of Bit		nne Arur	
Funer Direct		578-46-8055	1XXXM 2□F	67		nths Days		Min. (Month, Di	y, Year)		nplace (State or Foreign Intry)
		Usual Residence of Decedent						2/03/1	931	VIT	ginia
yland		10a. State 10b. County		10c. City, Tow	m or Locatio	n					10d. Inside City Limits
Mar Mar	ţ	MD Anne Ar	undel	Sever	n						1 ☐ Yes 2 🛣 No
r 28c	Director	10e. Street and Number			10	of. Zip Code			10g. Citiz	zen of What Cou	intry?
3 with	2	7959 Telegraph R	load, Lot	#104		22	144		Ţ	J.S.A.	
1215-0036 within 72 hours after death with the Maryland one. than "natural", or flams 23e or 28e-f show the Medical Examinating must be notified at	Filheral	11. Marital Status	12. Was Decede		13. Was I	Decedent of Hi	spanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Amer	ican Indian,
or Ite	i i	1 Never Married 202 Married	Armed Force					Puerto Rican, etc.)		Black, White	
Ogo on self.	2	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Date	es:	1 U Y	′es 2/CXNo	Specity:			Specify: Wh	ite
5-0 72 hc 72 hc	Completed	15. Decedent's E (Specify only highest gi		16a.	. Decedent's	Usual Occupa	tion		16b. Kir	nd of Business/fi	ndustry
21215-0036 Id within 72 hours aff giene. or than 'natural', or Its Medical Exam	2	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO N	of work done d OT use retired)	uring most of	rworking	Rowa	n Heati	ng &
2 de maria	٦	12			Sa	ales			Ai	rcondit	ioning
e filed of the other went.	B.	17. Father's Name (First, Middle, Las	t)				18. Mother's	Name (First, Middle	Maiden	Sumame)	
ylan	ļ	Russell Marsh					Nelli	e Frances	McCc	11ey	
# 8 5 E E		19a. Informant's Name/Relationship	(Type, Print)	196	. Mailing Ad	dress (Street a	nd Number o	or Rural Route Numb	er, City or	Town, State, Zi	p Code)
and 2 and 2 bealth a n 27 li		Elizabeth Marsh,	Wife	7:	959 Te	elegrapi	h Road	, Lot #10	4 Sev	ern, MD	22144
S 1 a		20a. Method of Disposition		20b. Place of	f Disposition			Date		ation - City or T	
		1 ☐ Burial 2/12/Cremation 3 [ 14 ☐ Donation 5 ☐ Other (Speci		160			1	/08/2004	Laur	el, Mar	v1 and
Baltimo permit. Page Department of Important: If any injury or	ei .	21. Signature of Funeral Service Lice		110000		ne and Address					
D Peg F	g	Janya 8	to ward					Fleck Fund g Road, La			
by 600, Acade to the price of the purial-transit the purial-transit the purial-transit the purial-transit the purial-transit the purial-transit transit the purial-transit transit tra	al		b. Ventri Due to (or Due to (or	rdial Infa as a consequence cular Fil as a consequence ary Arter as a consequence	of): brilla of): y Dise	ıtion					Approximate Interval Between Onset and Death
difficate ng physical as the t	Medi	IF FEMALE:									
COLGS, P.O. BOX or requires that the death certific been signed by the attending I should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		2 Fetal death t at time of death		oic pregnancy ar (specify)			23	3d. Date of delive Month	ery Day Year
s that	by P	Part II. Other significant conditions	contributing to deat	h but not resulting in	the underly	ing cause give	n in Part I.	23e. Did to	bacco us	e contribute to t	he cause of death?
arine a signal and	P							101	′es 2 🗆	No 3 ☐ Prot	ably 4 Unknown
	ompleted							24a. Was			psy findings available
The law ate has page 2 s	Ë							— autop		prior to co death?	mpletion of cause of
- te d	O	)	Γ					1 ☐ Yes	3€3£No	1 ☐ Yes	2 □ No
	o Be	examiner?	Hospital:			Other	11.00	Death (Check only o			
Phys this ral dii	⊢		1 Ulnp		tpatient 3	J DOA	4   Nursin	ng Home 5⊠ Resid			y)
ding I	<u> </u>	1 XNatural 5 ☐ Pending	28a. Date of I (Month,	Day Year) Ir	njury	28c. Injury Work		28d. Describe h	low injury	occurred	
Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be		**************************************	М		es 2 □ No	2011			
OVISION  or Attending after death.  Director: After in by the fune	Ē	4 Homicide determined	building,	tnjury - At home, fai etc. (Specify)	rm, street, fa	ictory, office		28f. Location (S City or Tow		Number or Rura	il Route Number,
pital urs a srel (	ပိ										
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ★ Certifying Pi (Check only 2 Medical Example)	miner: On the basis	of examination and	death occu	rred at the time ation, in my opi	, date and pl nion, death o	lace, and due to the o occurred at the time, o	ause(s) a	nd manner as si	tated.
the thin 2 the mptel	Med		and manner	stated.							
To To	1	b a c				29c. License				signed (Month,	
1		Stru Tie				D469	78		16R)	ARY 61	2009
10+1		30. Name and address of person who	completed cause of	f death (Item 23a) (	Type, Print)			3415	HA	MILTON	ST
10		Steven					t	3415 TY ATTSVII	LE	MD ZO	782
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	1						

Piease Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** February 4, 2004 12:20 A Marcopulos, Sr. Michael Robert /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/04/1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours XXXM 2□F Maryland 577-05-9972 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylend Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 🕺 🙀 No by Funeral Director Ft. Washington Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 USA 13105 Monroe Avenue 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify. 3℃Widowed 4 □ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Food/Safeway Warehouse Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mabel Lynch Theodore Marcopulos 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20744 Jean O'Leary / Daughter 13105 Monroe Avenue Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, cremetery or other place)
Wash. Nat'l. Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 02/09/2004 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility ge P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a Party Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Ogset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last within 24 hours aftar deeth. To the Funeral Director: After this cartificate has been signed by the attending physician completaly filled in by the funeral director, pega 2 should be datached for use es the buna Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitai 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29a. Certifier within 2 To the F 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Philip Bean Med. Ctr. P.O. Box 64 Hollywood, Maryland 20636 Jarboe MD James P. 82. Registrer's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

FEB 0 9 2004

State of Maryland / Department of Health and Mental Hygiene 03544 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas J. McFarland, Jr. 31. 2004 January 4:50 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3734 Patuxent Manor Rd. Davidsonville Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, NOV. 17 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 183-26-8589 Director 67 .1936 Pennsylvania Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Anne Arundel Maryland Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 3734 Patuxent Manor Rd. 21035 permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or itemating or other traumating. USA 12. Was Decedent Ever in U.S. Amed Forces? VAYes 2 □ No If Yes, Give Year or Dates: 1954–56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement 12th Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas James McFarland Mary Montague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. McFarland/ Wife 3734 Patuxent Manor Rd., Davidsonville, MD 21035 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) Lakemont Cemetery 2-4-04 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AWYESTIVE /Medical Due to (or as a consequence of): Examiner RENTRU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atter should be detached for in the past 12 months? Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4/Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 Yes in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 1 TYes 2 No within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 TSuicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signat 29d. Date signed (Month, Dey, Year) n 30. Name and address of person ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 9 2004

		·	1 - For State Registrar	State of Ma		-	rtment			and M		giene Reg. No	/ 11111	+ 03	545
	Physici /Medic		1. Decedent's Name (First, Middle, James H. Maybe								2. Date of De Month Februa:	De	y Year , 2004	3. Time o	of Death
	Examin		4a. Fecility Name (If not institution, g Laurel Regional	Hospital			Laur	e1	Location o			P	County of Dea	eorges	
W,	Funeral Director		5. Social Security Number 205-32-1591 Usual Residence of Decedent	Sex 7. Age	(In yrs. last birt	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da 12/25/	y, Yeer) 1942	Pen	thplece (State ountry) insy1vai	orForeign nia
	Maryland a-f show	tor	MD Howard		10c. City, Town	_	cation							10d. Inside (	City Limits
	death with the Maryland rms 23e or 28e-f show	ai Director	10e. Street and Number #8 Pfister Stre	et			10f. Zip	Code 0723				10g. Cit	izen of What C	ountry?	
036	should be filed within 72 hours after death with the Marylan nd Menial Hyglene and Menial Hyglene marked other than "natural", or items 23s or 28s-f show marked other than "natural", or items 23s or 28s-f show marked other than "second filed at marked by confiled at marked by the Medical Examination or confiled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 덫 Divorced	12. Was Decedent E Armed Forces?  1 ☐ Yes 2 N If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi Specify: Wh	te, etc.	
21215-0036	filed within 72 hours after Hygiene. other than "natural", or ite ent, the Medical Exercine	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5-2)	+)	(Give I life. D	ent's Usua kind of wor OO NOT us	k done d e retired)	uring most	of worki	ng		ind of Business mercial	•	ructio
Maryland 2	should be filed nd Mental Hygi smarked other umatic event, I	To Be C	17. Father's Name (First, Middle, La	est)					Bett	y Sw	(First, Middle, vitzer				
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Tamara A. Maybe		aughter	20	0006	Canel	brake	Cou		the	r Town, State, rsburg, ocation - City or	MD 208	386
Baltimore,	permit. Pages of Department of Himportant: If Ite any injury or ot once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spe	ocify)	20b. Place of cemeter. Balt-Wa	ash		ator	y 2	/09/			rel, Ma		
Ba	Depa impo any ii		23a. Part 1. Enter the disease, or conshock, or heart the disease. List or	ewart	the death. Dor	76	01 Sa	andy	Spri	F1 ng R	oad, La	ure	1 Home, 1, Mary	land 20	ate
	Pnysician /Medical		shock, or heart thingre. List or immediate Cause (Final disease or condition resulting in death)	a Cerebrov		r Ac								Interval Be Onset and 4 days	Death
	Examiner	ner	Sequentially list rorolltions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Cardiore		ory	Fail	ıre						1 hour	
8760,	ate be executed thysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Renal In  Due to (or as a	suffici consequence		у							6 mont	hs
O. Box 68	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pre						23d. Date of de Month	livery Day	Year
rds, P.	quires that in signed by ald be deta	b	Part II. Other significant condition	s contributing to death bu	it not resulting in	n the un	nderlying ca	iuse give	n in Part I.				use contribute t		
I Records,		Completed									24a. Was autop perfo 1 Yes	rmed?	prior to death?	utopsy findings completion of	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	-		(Check only o		1975		
ō	ing After une	ation: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injur (Month, Day	y 28b. 1	itpatieni Fime of njury		Bc. Injury Work			me 5∐ Resid 28d. Describe f		6 □Other (Spe ry occurred	ocify)	
Division	in Diffe	Certification;	3 Suicide 6 Could no 4 Homicide determin		ry - At home, fa . (Specify)	ırm, stre	et, factory	, office			28f. Location (3 City or Tox	Street an vn, State	nd Number or R	ural Route Nur	mber,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in I	Medical	(Check only 2 Medicel E:	Physician: To the best of caminer: On the basis of and manner sta	examination an	death d/or inv	estigation,	in my op	inion, dea	d place, th occurr	ed at the time,	date and	d place, and du	e to the cause(	(s)
•	To To Com	Σ	29b. Signature and title of certifier	5 MO			29c.		number	72		29d. Da	te signed (Mon	n, Day, Year)	
	V		30. Name and address of person w	7215-D Han	over Pa			reen	belt,	Mar	yland 2	2077	0	- 7- 1	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		5								

			1 - For State Registrar	State of Maryla	•	artment of H			piene 2004	03546
	Dhi.i.i		1. Decedent's Name (First, Middle,	ast) / -//				2. Date of Dear	th Day Year	3. Time of Death
	Physici /Medio		Byrdie	L. Mills				Feb	6 2004	12" M
1	Examir		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town, o	r Location of	Death	4c. County of Death	
			222 E. haf	ayette A	ve.	Pald	If Under 24	t Hre   0 Date of Birth	ajs	
	Funeral			Sex 7. Age (In yrs	. last birthday, Yrs.	Months Days	Hours	Min. (Month, Day	(Year) COL	place (State or Foreign
	Director		212-14-7083 Usual Residence of Decedent	97				10-3-	1906 Sou	th Carolina
	pue s		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	Mary	ច្ច	us N/A	L 6	Baldin	rore_				1 Dres 2 □ No
	128 the	9	10e. Street and Number		-070	10f. Zip Code		1	Og. Citizen of What Cou	entry?
	efter death with the Marylend or iteme 23s or 23s-1 show miner must be notified at	Funeral Director	222 t. Let	-avette Ave		2/2	-02		U.S.A.	
	death	Jera	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origi	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer	
9			1 Never Married 2 Married	Armed Forces?	1	1 ☐ Yes 2 🛣 No	Specify:	ruento rican, etc.)	Bleck, White	, etc.
93		ğ	3 DWidowed 4 □ Divorced	If Yes, Give Year or Dates:		TEL THE ZYPAINO	эрвспу.		Specify: /3/	rck
5-0036	72 hours "neture!",	Completed by	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup	during most o	of working	16b. Kind of Business/li	ndustry
21		d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	•		med.	6.1
2	filed within I Hygiene. other than	ပိ	12		1	hurs-		AL (5) A MINUTE		caj
Pu	D d ot H d ot H d ot H d	To Be	17. Father's Name (First, Middle, La	st)				s Name (First, Middle, I	Maiden Sumame)	
Ş	should be nd Mentel marked o	၉	beurge den	Kins				rva Wa	shirg for	-
Maryland	0 0 2		19a Informant's Name/Relationship	(Type, Print)	19b. Maili			11 /	City or Town, State, Zi	•
	end eelth m 27		Regina Masu	r daughter	222	osition (Name of	ayel	Date		21202
9	pes 1 er t of Hee If item or othe		20a. Method of Disposition 1 Ø-Burial 2 □ Cremation 3	- 1 .	cometery, cre	matory or other pla	W. L	Date	20c. Location - City or T	own, State
Ē	ment:		*4 □Donation 5 □ Other (Spe	704	1. Mah	mel for for	1C KA	412, 2004	Laurel, M	a · , ,
Baltimore	permit. Peges Department of I important: If its any injury or o		21. Signature of Funeral Service Lic	rensee	1	2. Name and Addre	ss of Fichty	algos fu	nend Legar	ce f.t.
_	20 E E G		Callon C.	Wanglan		170/ Mc	Cullos	CIT. Ball	10. W. z	1217
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the dealy one cause on each line.	eth. Do not en	ter the mode of dyir	ng, such as ca	ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death
4	Physician	0 1	Immediate Cause (Final disease or condition	. AL21	E NE	20 D	Ene	ENTIA		Onset and Death
7	/Medical		resulting in death)	Due to (or as a conse			,			
и	Examiner		Sequentially list conditions	b. #78	ENTE	-N8100	$\sqrt{}$			
	p =	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
	acute and trens	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	e DIA	<u> </u>	= 5 11	EU T	3		
Ö,	sate be executed thysician end the burlai-trensit		lesding in death, Last	Due to (or as a conse	quence or):			(		
8760,	ate be hysicia the bur	lcal		d				<del></del>		
9	leath certifica ettending ph	by Physician/Med	IF FEMALE:					1		
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	tel death 3	Ectopic pregnancy	y		23d. Date of delive	ery Day Year
	he etter	200	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (specify)			\	,
P.O.	thet the ed by the detache	된		annichturing to dooth but out o	aution in the .	undaskijan savjag siji	on in Bort I	23e Did tot	bacco use contribute to	the cause of death?
	8 5 5	۵	Part II. Other significant conditions	s contributing to death but not re	suling in the t	indenying cause giv	en in Fait i.	1 \( \text{Ye}	1	babiy 4 Dunknown
Division of Vital Records,	w requires been sign should be	Completed			·				95 272140 30110	Dably 4 Donkhown
Ö	2 S T	호						24a. Was a autops	v ∧ l prior to co	opsy findings available ompletion of cause of
<u> </u>	F seg	ő						perform 1 ☐ Yes 2	med/? death? 2☑No 1☐Yes	2 □ No
'ita	Physicien: The this certificate rel director, pag	Be	25. Was case referred to medical examiner?					of Death (Check only on	(0)	
>	Physic this correct dire	၉	1 ☐ Yes 2 ☑ No		☐ ER/Outpatie		4 🗀 INUIS	ing Home 5 meside	ence 6 Other (Speci	fy)
0		Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	yat k?	28d. Describe ho	ow injury occurred	
Ö	death. ctor: A	at	2 ☐ Accident investigat			M 1 🗆	Yes 2 □ No			
Σ̈́	r Att	Ĕ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		home, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number or Rur n, State)	al Route Number,
	To the Hospital or Attending within 24 hours eiter death. To the Funeral Director: Atter completely filled in by the funer	Certification;						- N		
	dep 4 hou fune aly fil	edical	(Check only 2 Medical Ex	Physician: To the best of my kr aminer: On the basis of examir						
	the	P	one)	and manner stated.						
	To Too	Σ	29b. Signature and title of certifier	ATTENNING	Piku	29c. Licens			9d. Date signed (Month,	
				ATTENDING	1 1731	- DOG	0 7 6	1 7 8	res 91	5007
	m		30. Name and address of person with	o completed cause of death (Ite	ет 23а) (Туре	Print)	1 /	1005 D.	Fe's 9th 1	70
			0////		122	DOUTHI	15 0	1401 /3A	M WOLL 1	り
	Sta Registi		31. Date liled (Month, Day, Year) FEB 0 9 2004	32. Registrar's Sign	nature	6 -				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Year Estelle J. Moreland February 6, 2004 /Medical 9:30 am 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Care Center E1kton 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 X F Months Director 222-09-0398 81 Dec. 27, 1921 Delaware Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits Maryland Cecil Elkton 1 Yes 2 □ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive Funeral 21921 United States 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Exercises 2008. 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 15√Yes 2□No *Specify:* Puerto Rican 3altimore, Maryland 21215-0020 ð 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Michael Albanse Nola Fernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Barbara Sayers/ Daughter 40 Union Valley Road Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/10/2004 Odenton, Maryland West Arundel Crematory 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gift Registry Hanover, Maryland lanita nomaro 7526 Connelley Dr. Suite E. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final in MENTAL STOTUS CHANGE disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner  $/\Delta$ or Attending Physician: The law requires that the death certificate be executed bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in Jeath) Last end Due to (or as a consequence of): physician s the bunal Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to for as a consequence of as DEMONDO 77460 esn signed by the atter d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? peen has 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral ( completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the Ewithin 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 10/20 1002 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of COR NEW USIN DE 1872 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 9 9 2004 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		•	State of Ma 1- State of Ma 1- State Dvr/Dr., Registrar	C828,02/05/	artment of He Oddhb Intilicate of D	eaith and M <i>eath</i>	entai mygie Reg	200L	03548
	Dhusiair		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al .	Maria M. Magtib	ay	T		January 7,	4c. County of Deet	9:20p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) 9600 Northwind Road		4b. City, Town, or L Baltimore			Baltimore	n
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birt	hplace (State or Foreign puntry)
	Director		219–94–1554 1 M 2 XF 87  Usual Residence of Decedent	Yrs.			Dec. 8,191	6 Phi	lippines
	yland		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	e Mar	ctor	MD Baltimore	Baltimore					1 Yes 2 XNo
	with th	Dire	10e. Street and Number		10f. Zip Code		1	. Citizen of What Co	untry?
	Jeath of 23	eral	9600 Northwind Road  11. Marital Status 12. Was Decedent E	ver in U.S. 13.	21234 Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe	USA ecify Yes or No-	14. Race - Ame	
21215-0036	s i and 2 should be filed within 72 hours after death with the Maryland f Health and Mentai Hygiene. If marked other than "natural", or Itema 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ Norced 2 ☐ Wildowed 4 ☐ Divorced  A med Forces? 1 ☐ Yes Cive Year or Dates:			Specify:	Rican, etc.)	Specify: Fil	
5-0	n 72 hc	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupati e kind of work done du DO NOT use retired)			b. Kind of Business	Industry
121	within lene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5-12)	-)	Retailer			Self-Employ	ed Retailer
9	be filed stal Hygi of other avent, I	Be C	17. Father's Name (First, Middle, Last)		1		(First, Middle, Ma		
yla	should be nd Mental marked o	2	Luis Maderazo				Apuntar		T. O. 4.)
Mar	d 2 should be and traum		19a. Informant's Name/Relationship (Type, Print)  Mrs. Sionie Geronimo (daughter)		ing Address (Street an Northwind Ro			•	zip Code)
Baltimore, Maryland	s 1 and 3 Health item 27 other tr		20a. Method of Disposition	20b. Place of Disp				c. Location - City or	Town, State
Ē	Peges ment of I ent: If its ury or o		1  Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	Dulaney Va		1/12/	'04 <u>T</u> i	imonium, MD	
Balt	permit. Peges 1 ar Department of Hea Importent: If Item any injury or other		21. Signature of Funeral Service Licensee  Brian Lewis per DVR	9	22. Name and Address 2705 Belair R	d., Baltim	nimunek Funk ore, MD 212	236	
<b>&gt;</b>	Physician		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	the death. Do not en	nter the mode of dying,	such as cardiac o	r respiratory arrest	Teda	Approximate Interval Between Onset and Death IMPLECIAL
	/Medical Examiner		Sequentially list conditions	consequence of):	4 ART	Eng	101560	ase	4 less
	led sift	Examiner	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause (Disease or injury	consequence of):	7				4 Pars
Ć.	ficate be executed physician and is the burial-transit	Exan	that initiated events c.	consequence of):	0.0+0	16-6	-		
68760,	nte be nysicia ne bur	edlcal	d. 74 p	0 1	). 146	1177-0	0		geons.
_	± 00 m		IF FEMALE:				13.315		
P.O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 23c. If yes, outcome of 10 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
	s that gned b	by PI	Part II. Other significant conditions contributing to death but				23e. Did tobac		the cause of death?
ord	equire	ted	CUA, Rt	.60	11		1 🗆 Yes	2 <b>X</b> No 3 □ Pr	obably 4 Unknown
Division of Vital Records,	The law are has b	Completed	CUA, RT	lt c.m	phies	79	24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1. Type 2. Who Hospital: Hospital:				(Check only one)		
ō	y Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injur	nt 2 ER/Outpatie	of 28c. Injury a	at :	me 5 🐒 Residenc 28d. Describe how	ce 6 Other (Spe injury occurred	city)
ion	Attending F r death. actor: After by the funer	atlo	1 XNatural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	Work? M 1 □ Ye	es 2□No			
Divis	i or Attendati after deati Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
_	Hospite 4 hours Funeral ely filled	edical Ce	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of and manner star	examination and/or i					
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License		29d	. Date signed (Mont	
	1		> purs	s vil	D17679			119/04	
	60'		30. Name and address of person who completed cause of de Agaton H. Escalante, MD 8870 I			21236			
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registra	r's Signature					

		1	For State Registrar	State of Maryla		artment of H			ene . No. 200	4 03549
/	nysicia Medic xamin	an al er	Decedent's Name (First, Middle, Last)     ANNA J. MATEJSKI     Aa. Facility Name (If not institution, give s     GENESIS ELDERCAR	treet and number)		4b. City, Town, or  DUNI  If Under 1 Year	Location of Death  OALK  If Under 24 Hrs.	2. Date of Death Month FEB. 1,	Day Year 2004 4c. County of Do	12:10 PM  Beath  CMORE
	neral ector		5. Social Security Number  6. Sex  216-05-9460  Usual Residence of Decedent	IN OUT	s. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y JULY 7,	1912 9. E	Birthplace (State or Foreign Country)  MD.
death with the Maryland	ified at		10a. State 10b. County N/A		City, Town or Lo BALTI					10d. Inside City Limits 11√ Yes 2 □ No
th with the	to eq te	al Director	10e. Street and Number 635 S. EATON STR	EET		10f. Zip Code	21224	1 '	U.S.A.	
je je	al Exeminer must be notified at	by Fur	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2ሺ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: V	
within 72 hours af	Le Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work ()	ing 16	Sb. Kind of Busine	
vid be filed	tic event, I	To Be Co	17. Father's Name (First, Middle, Last)  JOHN BRODKA					e (First, Middle, Ma	aiden Sumame)	
e, Mary 1 and 2 shou Health and M	er trauma		19a. Informant's Name/Relationship ( $ au_{ m M}$ ) TINA A. HALL/GUAR	DIAN	519	S. SHARP	ST., BAL	TIMORE, N	IARYLAND	21201
se to	ury or other		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)		cemetery, crei HOLY ROS	osition (Name of matory or other place SARY CEMET	TERY 2/6	/04 I		E, MARYLAND
Dermit.	any injury o		21. Signature Funeral Service Lense	emelf 1	2057 6	5224 EASTI	ERN AVE.,	BALTIMOF	RE, MARYI	SON, INC. LAND 21224
/oU,	dical niner prize	Ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.  A THELOSO  Due to (or as a cons	sequence of): sequence of):	TIC CARI X DISM				Approximate Interval Between Onset and Death
D. BOX on the death certif	tor use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of Month	delivery Day Year
rdS, P.	speed signed by the should be detached	þ	Part II. Other significant conditions con	-	resulting in the u	underlying cause giv	en in Part I.		_	e to the cause of death?  Probably 4 Unknown
VITAI RECORDS, sician: The law requires t	2 8	Completed						24a. Was an autopsy performe 1  Yes 2	prior	
VITE	s certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatie	nt 3 DOA Oth	00	th <i>(Check only one,</i> ome 5□ Residen		Specify)
DIVISION OF 1 or Attending Phys after death.	To the Funeral Director: Atter this certificate in completely tilled in by the funeral director, page	Certification; T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		M 1	y at k? Yes 2 □ No	28d. Describe how		
- Page 1	aral Direct		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.			and place	City or Town,	State)	Rural Route Number,
To the Hospital within 24 hours	ne Fune detely ti	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exam and manner stated.	nination and/or in	nvestigation, in my o	pinion, death occur	rred at the time, dat	e and place, and	due to the cause(s)
To the within	To t	ğ	29b. Signature and title of certifier	1/ Trason	111	29c. Licens	e number	296	d. Date signed (M) $g/J/J/J$	onth, Day, Year)
	2		30. Name and address of person who co	ompleted cause of death (	Item 23a) (Type	, Print)	DI	2 1	11/	2/222
	2 Sta	ate	31. Oate filed (Month, Day, Year)	32. Registrar's Si	2 Ma	wet t	ace s	Dunko	W MD	11222
	Regist	rar	FFD 0 9 2004	0 1 5	S. S					

			1 - For Registrar	State of M	aryland /		nent of H		nd Mental	Hygien	/111		03550
à			Decedent's Name (First, Middle, La	ast)					2. Date of	of Death			3. Time of Death
	Physici		GLENN	LOUIS	MOR	RISON			Jan	vary	25 2	604	11:20 M
	/Medio		4a. Facility Name (If not institution, gi				City, Town, or	Location of			c. County of		
			Washington C	ounty Ho	spital		Hagers				Wash	ning	ton
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. last b		Inder 1 Year	If Under 24 Hours	Hrs. 8. Date of (Montile December 1)	f Birth	r) 9	Birthpla Country	ce (State or Foreign
3	Director		173-05-4217	X□M 2□F	92	Yrs.	Titils Day's	110013	Decembe	er 17,	1911	Kans	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wo or Location	0					100	d. Inside City Limits
	sho sho	ō				rstow							1 X Yes 2 □ No
	the N	ect	Maryland Washin  10e. Street and Number	gton	Ilage		of, Zip Code			100.0	itizen of Wh	at Countr	,,
	with	<u>=</u>	1158 Luther D	rive		1.	21740	1			U.S.A		, .
	leath	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was I			n? (Specify Yes o		14. Race -		n Indian,
"	r Itan	E	1 ☐ Never Married 2 💢 Married	Armed Forces	?				n? (Specify Yes o Puerto Rican, etc	.)	Black,	White, et	c.
93	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	MMII	1 U Y	es 2 XNo	Specify:			Specity:	Whi	te
21215-0036	within 72 hours after death with the Maryland sne. than "natural", or Items 23e or 28e-1 show ite Modical Experiment has be redilled at	Completed	15. Decedent's E (Specify only highest gr		168	a. Decedent's	Usual Occupa of work done d	ation	of working	16b.	Kind of Busin	ness/Indu	stry
21	thin 6	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO N	OT use retired)	)	a working			-	
2	ed wi	Co		4		Acco	untant				rintin	ig Co	mpany
pu	be filed ital Hygid of other event,	Be	17. Father's Name (First, Middle, Las Merton Le		orriso	_			s Name (First, Mi	ddle, Maide		_	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event, Ite Medical Extrainer, and by Itemiliard at	မ						Ιva				ley	
Jar	12 sh and ris m	1 9	19a. Informant's Name/Relationship			•			or Rural Route N				
	1 and Health em 27 ther tr		Virginia G. Ma 20a. Method of Disposition	orrison N		$1158$ $^{f L}$		DLTAG	, magers		Mary⊥ ocation - Ci		
ğ	iges if of the		1 Burial 2 Cremation 3	Removal from State	Smithsb	urg Cr	emator:	ium ∤ O	1-29-04				aryland
Baltimore,	permit. Pages Department of t Important: if Ite any injury or of		' 4 ☐ Donation 5 ☐ Other (Special Service Dice	fy)		_		Ī					
Ba	Depa Impo Impo Inny lo		R. Roel Dru			And:	rew K.	Coffr	man Fune	raļ Ho	ome, I	nc.	Md. 2174(
		100			d the death. Do	not enter the	mode of dvino	III L T E I	tam St.	, Hagi	ersto		Md. 21/4( Approximate
, i			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each				, , , , , , , , , , , , , , , , , , , ,		,		10	nterval Between Onset and Death
	Fhysician /Medical		disease or condition resulting in death)	a	Sep								رخع
	Examiner		-	Due to (or as	a consequence	of):							
		- G	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence		and d					3	درس، ای
1	rted	E I	if any, leading to immediate cause. Enter Underlying	con	to Very	. ten	Acu	-	Allera,			5	-6 Am
<u>,</u>	execu n and ial-tra	Examine	that initiated events resulting in death) Last	C	a consequence								
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit			⊾ d.									
9	ifficate g phys as the	Physician/Medical											
Вох	eath certific attending p I for use as	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal deat	h 3DEsta	pic pregnancy				23d. Date of	of delivery	,
	ne deat the att	icia	in the past 12 months?		t time of death		or (specify)			-	Month	ı D	ay Year
P.O.	by tac	hys	9 Unknown	9LI UNKNOWN									
	gned be de	by F	Part II. Other significant conditions	contributing to death	,,,,,		ring cause give	n in Part I.	23e.	Did tobacco			cause of death?
ord	w requires to been signer should be	ted	Myselling	chronic	oble	elei	pulm		U	1 ☐ Yes 2	2 □ No 3	Probab	oly 4 <del>JUnkrio</del> wn
၁၁	2 5 8	ompieted	Duren De	mentin						Mas an autopsy	24b. We	re autops	y findings available detion of cause of
of Vital Records,	The ate h page	Сош								erformed?	dea		
ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of	f Death (Check o	nly one)			
>	S S D	욘	1 Yes 2 4No	Hospital: 1 4mpati	The second second	utpatient 3[	DOA Othe	1: 4 🗆 Nursi	ing Home 5□I	Residence	6 Other	(Specify)	
		:u	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. ay Year)	Time of Injury	28c. Injury Work	at ?	28d. Desc	ribe how inju	ary occurred		
<u>S</u> i0	Attending r death. sctor: After by the fune	cati	2 Accident investigation			M	1 D Y	′es 2 □ No	>				
Division	l or Attendafter deati	ertification:	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of in	jury · At home, f tc. (Specify)	arm, street, fa	actory, office			on <i>(Street a</i> r Town, Stat		or Rural F	Route Number,
Ω	Hospital or 24 hours afte Funeral Dir tely filled in I	0											
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of	of examination a	je, death occi nd/or investig	urred at the time ation, in my op	e, date and p inion, death	place, and due to occurred at the ti	the cause(s me, date an	s) and manne id place, and	er as state I due to th	ed. ne cause(s)
	To the l within 2. To the I	Med	one) 29b. Signature and title of certifier	and manner s	14160.		29c. License	number		29d D:	ate signed (//	Month Da	v Year)
	F 3 F 8		- CENT	AL D			D180			1	~ 26		*
	1	11	30. Name and address of person who		death (Itam 22-)	(Type Brien)	- 6	- ` [				, 2.0	U = (
	1		VASAWT DAT				1445	T 17A	IGERS -	76W~	mo	) 2	1740
A.	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signature		4 *						
44	Registr		FET	0 9 2004	La com	· K	Ange!	7					

		1 - For State Registrar	State of Marylar		artment of H			giene Reg. No.	2004	03551
Physic /Medi		Decedent's Name (First, Middle, Last)  Jerimiah		Moult	rie		2. Date of Dea Month	Day 3rd	Year 2004	3. Time of Death 7-35 PM
Exami		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea		4c. Cou	nty of Deeth	
Funeral		Union Memorial  5. Social Security Number 6. Sex			Baltin If Under 1 Year Months Days			h y, Year)	n/a 9. Birthpla Countr	ice (State or Foreign
Director		248-72-3863 Usual Residence of Decedent	<sup>M 2□ F</sup> 62	Yrs.			Dec.25	,1941	Sout	<u> </u>
death with the Maryland ms 23a or 28a-f show FITIEST for mylified at	J.	10a. State 10b. County	10c. Ci	ty, Town or Lo					100	d. fnside City Limits
the M 28a-f	Funeral Director	MD n/a 10e, Street and Number		Balt	imore			10a Citizen	of What Countr	
3a or	D	1819 Chilton S	S.+ .		212	218			U.S.	•
death	nera		Was Decedent Ever in U     Armed Forces?	l.S. 13.	Was Decedent of Hi ff Yes, specify Cuba		Specify Yes or No-	14. F	Race - America	n Indian,
3-UUSO 72 hours after naturel; or its	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🗓 No		to ricall, etc.)		Black, White, et cify: Black	
Maryland 21215-UU30 nd 2 should be tiled within 72 hours after death with the Marylan lilt and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show treumatic event, tra Medical Examplement metimest by multiputal.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of we	orking	16b. Kind of	f Business/Indu	stry
d 21, tilled with Hygiene sherther the	Con	12th			Custodi					Hospital
Date in the track of the track	Be	17. Father's Name (First, Middle, Last)  Jessie Moultri	0				me (First, Middle,		ame)	
Irylar should be nd Menta marked matic ev	ဥ	Jessie Moultri  19a. Informant's Name/Relationship (Typ.		19h Maili	ng Address (Street a	Ess		ce c City or Top	wn State Zin (	Code)
Ma 2 s ulth an 27 is r treu			ie/wife		9 Chilto			MD 21	Value Carrier Co	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
of Her		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place	e)	Date		on - City or Tow	n, State
Page Page ment of ant: M		1 ⊈Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State   Be-	thleh	emBaptis Cemetery	it. !	.10,200	4Alvi	n. S.0	
Baftimore, Marylar permit. Pages 1 and 2 should by Oppartment of Health and Menta Important: If Item 27 is marked any njury or other traumatic enones.		21. Signature of Funeral Service 1 se		22	2. Name and Addres	s of Facility	GS FUNE			213
bayboling the private personned by the private personned by the private personned as the private personned by the personned by the private personned by the personn	cal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Finaf disease or condition resulting in death)  Securities, list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a)	Brain guence of):  La	iojuy lema	g, such as calling	ic or respiratory an	(OS),	1	Approximate niterval Between Onset and Death
death certific	by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Sc. If yes, outcome of pregns 1 Live birth 2 Feta 4 Pregnant at time of c	ıl death 3 [	Ectopic pregnancy Other (specify)				Date of delivery Month D	/ Jay Year
		Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	nderlying cause give	on in Part I.		obacco use co ′es 2 □ No		cause of death?
On Of VII.al RECOIDS, F.O. ding Physicien: The law requires that the h. After this certificate has been signed by the funeral director, page 2 should be detach	Completed						24a. Was autop perior 1 Ves	sy med?	b. Were autops prior to comp death? 1 \( \text{Yes} \) 2	y findings available pletion of cause of
OI VITAI Physicien: this certitics ral director, p	Be	25. Was case referred to medical examiner?	ospital:		Othe		ath (Check only o			-
Phys or this orat di	1: To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	f 28c. Injury	at	Home 5 Resid			
Attending in death. ector: Atterby the funeing	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1□	(? Yes 2 □ No				
DIVISION OI  al or Attending Phy s atter death. Il Director: Atter this id in by the funerat d	Certification:	3 Suicide 6 Could not be determined	28e. Place of friury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox		mber or Rural i	Route Number,
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	h occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the ourred at the time, o	ause(s) and date and plac	manner as state, and due to t	ted. he cause(s)
To th To th compl	Me	29b. Signature and title of certifier	1		29c. License				ned (Month, Da	
		I gami Veerak	laphavan		ATQ	24389	46	Jebrua	y 4th	2004
Ý		30. Name and address of person who con			Print) OWR 201,	I. VEER	ARACHAN VERSITY )	PARKWA	7	
Sta Regist		31. Date filed (Month, Day, Year)	Registrar's Signe	ature	also	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:20 a<sup>M</sup> February 2004 Ellwood Lincoln Manner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Feb. 12, 1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 SM 2 □ F Pennsylvania 85 215-10-7716 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County ral, or items 23a or 28a-f show Exercises must be notified at 1 Yes 2 No Baltimore Baltimore Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 100 Spring Towne Circle #3B Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3x Widowed 4 ☐ Divorced "natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Steel Consultant and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dorothy Marie Toland John Manner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other tratonce. 9111 Simms Ave. Baltimore, Md. 21234 Mr. Gary Manner/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Md. Parkwood Cemetery 2-10-04 \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home
1050 York Rd. Towson, Md 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ears **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially "sit conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit Due to (or as a consequence of): Box 68760. attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of I Director: After t d in by the funera MANNER. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title uns 30. Name and address of person who completed cause of death (Item 23d) (Type, Print) . Charles St. Balts Md 21205 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 09 2004 FEB A roade Registrar

		-	For State Registrar	use		of Marylar	nd / Depa		t of H	ealth a	and M	lental Hy		200	4 03553
Œ	w 7		1. Decedent's Name (First, Mi	ddle, Lasi	")							2. Date of De Month	ath Day	Yea	3. Time of Death
	Physici		MARY	Α.	N	ELSON						FEBRUAI		2004	
	/Medic Examin	5	4a. Facility Name (If not institu	tion, give	street and nu	ımber)		4b. City,	Town, or	Location				County of D	
		elet	MARINER HEALT	H OF	GLEN	BURNIE		GLEN	BUR	NIE			AN	INE AR	UNDEL CO.
2 2	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th V. Year)	9. 8	Birthplace (State or Foreign Country)
345	Director		215-07-5628	1[	□M 2∏ F	88	Yrs.	Wichtins	Days	Tiours	Dec	29 19			larvland
	<b>P</b> .		Usual Residence of Decedent			140.0									10d. Inside City Limits
	how test		10a. State 10b. Cou	-	1 1 6		ty, Town or Lo		,						1 ☐ Yes 2 ☑ No
	Ba-f	ct		e Aru	indel C	0.			aden	a,					
	를 다. 20.22 20.23	- Pre	10e. Street and Number	.1				10f. Zip		100			10g. Citiz	zen of What	·
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ebow edical Evantret mast be notified at	Completed by Funeral Director	791 Woods Ro	oad .						122				U.S.A	
	r de	Ine	11. Marital Status		Armed F		J.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		14. Hace - A Black, W	merican Indian, hite, etc.
36	or H	YFL	1 Never Married 2 N		If Yes, G	2 No ive X		1 🗀 Yes	2 💢 No	Specify:				Specify:	white
21215-0036	hours after ture!, or Ite	q p	3 Widowed 4 □ Divor		Year or I	Dates:	10= D	dantin thu					10h Ki	ad of Busines	
7	"nat	lete	15. Dece (Specify only hig	hest grad	ucation de completed,	)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	nk done o	ition luring mos	t of worki	ing	160. Kii	nd of Busine	ss/industry
2	withir than	Ę.	Elementary/Secondary (0-1	2)	College	(1-4or 5+)	1	kkeep		,			I.a	urel :	Dodge
	be filed withir ntal Hygiene. od other than event, I're My	ပိ	17. Father's Name (First, Midd	lle, Last)				Т		18. Mothe	er's Name	(First, Middle			Douge
au	Q 22 D 9	Be	Lawrence		L.	Apple	hv			Gra	ce	I.			Bosley
2	2 should be and Mental ie marked aumatic ev	<u>٩</u>	19a. Informant's Name/Relati				_	na Address	(Street a	_	_	A Route Numb		Town, State	
Maryland	ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		James B. Atki			Son)		_				ena, Mo			
	permit. Pages 1 and 2 Department of Health & Important: If item 27 i any injury or other tra ance.		20a. Method of Disposition		`		Place of Dispo cemetery, cre		Mark to the second			ate			or Town, State
و	ages nt of nt of t: If it		1 Burial 2 ☐ Cremati	on 3 □	Removal from		cemetery, cre ruid R				<u>02/0</u>	0/0/	Ro I	timor	e, Md.
Baltimore,	permit. Pa Departmen Important: any injury QDCB.		* 4 ☐ Donation 5 ☐ Othe 21. Signature of Fungral Serv				1	_		-					
Ba	perm Depa Impo any i		21. Signature of Fundan Serv		DA.	0-10/		Me	cCu1	ly-Pc	lyni	ak Fune	ral	Home	p.A.
		-	220 Paris Fotor the disease	J.	ACIV	caused the dea		3.	ZU4 1	Moun t	aın	Koad. E	asad	ena. I	Md. 21122 Approximate
	Physician		23a. P. rt1. Enter the disease hock, or heart failure.  mediate Cause (Final disease or condition resulting in death)	ist only	a	Me to	ista	tic	B	reas	+ (	Pancel	-		Interval Between Onset and Death
	/Medical Examiner		Tooling in Journ,		Due to	(or as a conse	quence of):	1.		Pa	erin				
		-	Sequentially list conditions,		b. Due to	(or as a conse		16/10		1 710	. Copp	UPLIPT			7.1.4.1
	led sit	nine	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	≺	20010	1 4	TN								
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last		c	(or as a conse	quence of):			4					
760,	e be ey /sician e buria	calE				City	quence of):	Fib	rel	1147	700				
687				-	d										
×	The law requires that the death certificate is the has been signed by the attending physionage 2 should be detached for use as the topical process.	Physician/Med	IF FEMALE:		23c. If yes, or	utcome of pregn	ancy						,	23d. Date of	delivery
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 Fet	al death 3	□Ectopic pr □ Other (sp						Month	Day Year
P.O.	t the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ļ	9□ Unki				7/						
	res that the igned by be detact	Ph	Part II. Other significant con-	ditions co	ontributing to	death but not re	sulting in the t	inderlying c	ause give	n in Part I		23e. Did t	obacco u	se contribute	e to the cause of death?
ds	sign d be	d by										1 🗀	Yes 2[	_No 3 _	Probably 4 Sunknown
of Vital Records,	w requir been si should	Completed						_				24a. Was	17	24h More	autopsy findings available
3ec	has has	I I I										auto		prior	to completion of cause of
<u>=</u>												1 ☐ Yes		1 🗆 Y	
Žį.	ysician: is certific director,	Be	25. Was case referred to med examiner?		Hospital:	-			Othe		/	(Check only o			
o	Phys this al di	۴	1 ☐ Yes 2 ☐ No 27. Manger of Death	2010	28a. Date	Inpatient 2	ER/Outpatie		JA	4 -N		me 5 Resi 28d. Describe			(pecify)
L C		lo	1 Natural 5 □ Pe	nding	(Mo.	nth, Day Year)	Injury	M	28c. Injury Wark	γαι ∢? Yes 2□		zou. Describe	now injury	y occurred	
Sic	en or: he	cat	3 ☐ Suicide 6 ☐ Co	estigation uld not be		e of Injury - At I	omo form of			163 2		29f Location /	Stroot and	d Number or	Rural Route Number,
Division	in the	Certification:	4 Homicide def	ermined	buile	ding, etc. (Spec	ify)	reet, ractory	y, onice			City or To			ridia riodo italibor,
	Hospital 14 hours a Funeral C		20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	fuine Dh	vojaja pu Ta sh	a bast of multiple				data a	<u> </u>				an stated
$\vee$	Hos 24 ho Fun Fun tely f	lica	(Check only 2 Medi	cai Exam	niner: On the	ne best of my kn basis of examin	ation and/or in	n occurred ivestigation	, in my of	oinion, dea	ath occurr	ed at the time,	date and	place, and o	due to the cause(s)
7	the the	Medical	one) 29b. Signature and title of cell	triler	and ma	inioi stateu.		294	c. License	number		1	29d. Det	e signed /Mo	onth, Day, Year)
<b>N</b>	To To	-	250. Signature and Miles	1		0.		7	\ / \ /	151	1/5:	10	12	mon	4 1. 7004
	,1		1 4 M	1)	we	ew		(3)	) ()		100		Jel)	rucer	4 4 2001
	h		30. Name and address of per	son who d	completed cau	ise of death (Ite	m 23a) (Type	Prov	to a	215	Si	in Bu	10	un	21061
			300 HZ	20	2726	DY & F	-C	in	w 0		ou		(10)		onth, Day, Year)  Y 6 200 4  2006
	Sta		31. Date filed (Month, Day, Y	ar)	32.	megistrar's Sign	A A	book	2						
	Regist	ar	EFR 0 9 2	UU4_	16.12 E. B 38.4	/	- /1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 02 05 Irene Rose Orsini 2004 10:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4045 Gilford Court Harford Jarrettsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 04/18/1917 86 Director 214-24-1050 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or Itema 23s or 28s-f show the Modical Examiliars must be notified at 1 ☐ Yes 2√ No Funeral Director Jarrettsville Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4045 Gilford Court 21084 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaking other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John McCadden Rose Marie Prietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 if item 27 Dolores D. Mobley (daughter) 2811 Summit Avenue - Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Highview Mem. Gdns. 02/09/2004 Fallston, Maryland \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 00 11750 Belair Road - Kingsville, MD 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hews Immediate Cause (Final Longest I've Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed should be detached for use as the burial-transit Due to (or as a consequence of): attending physician Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 1 Yes 2 No 2 Z No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Alter 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Momicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier thint Valley, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2004 Registrar

				1 - State Registrar	State of Ma	arylar				lealth a			Reg. No	6 U U	de de la company	03555
_		Physici /Medio		Decedent's Name (First, Middle, Last)     ANNA M. OSWINK								2. Date of De. Month	Da Z	20	04	3. Time of Death  5/57 PM
		Examir	ner	4a. Facility Name (If not institution, give st	11	pil	Al	R	ose	dA/e					-	ORE
		Funeral Director		5. Social Security Number 06. Sex 219-05-5552	M 2√ F 7. Age	in yrs. 84	last birthday) Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bin Month, Da JAN . 1	th y, Year, 8,	1920	Birthpla Country	MD.
		ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							100	I. Inside City Limits
		r 28e-f	recto	MD N/A		·	BALT		ip Code				10g. Ci	tizen of What	Country	1  Yes 2 No
16		172 hours after death with the Maryland "netural", or Items 23s or 28e-f ehow circal Experiment out be notified at	Completed by Funeral Director	TTT TIME TO THE TOTAL THE TOTAL TO AL TO THE	2. Was Decedent 6 Armed Forces?		J.S. 13.	Was Dec		1224 ispanic Or in, Mexicar	igin? (Spe	cify Yes or No Rican, etc.)		U.S.A. 14. Race - A Black, W		
X	9000	72 hours afte "natural", or It	d by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ XN If Yes, Give X Year or Dates:	lo		1 🗆 Yes	Λ.	Specify:			10)		WHIT	
Swin	21215-0036	within 72 hours after ene. than "natural", or ite ite Wedcal Exemite	mplete	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12TH	completed) College (1-4or 5	+)	1	odent's US be kind of w DO NOT OMEMA	ork done o use retired	ation during mos f)	t of workir	ng	16b. K	(ind of Busine		stry
Q,	N	Hygi ther nt, 1	To Be Co	17. Father's Name (First, Middle, Last) MILTON ANDREW WIE	NECKE		1 11	OTIDITI	KLIK			(First, Middle,	Maider		OFIE	
4x	Maryland	and 2 should be i ealth and Mental I m 27 is marked o her traumatic eve		19a. Informant's Name/Relationship (Type DONALD J. OSWINKL				-				ALTIMOR				
A	Baltimore,	0 0		20a. Method of Disposition 1	moval from State	-	Place of Disponentery, created the LAWN	osition (Na matory or	ame of other plac	:e)		ate	20 <b>c.</b> L	ocation - City	or Town	
	Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	much.	noc				ss of Facili	y CHA	ARLES S BALTIM	. ZI	EILER 8	& SO	N, INC.
•		Pnysician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition	cause on each lin	10.			de of dyin	g, such as	cardiac o	r respiratory ar	rrest,		lr.	pproximate sterval Between onset and Death
		/Medical Examiner		resulting in death)	Due to (or as:		1	1.7.3.							6	DAYS
K	)	and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. En acriying Cause (Disease or injury that initiated events c.	Due to (or as										ľ	,
	8760,	icate be executed physicien and s the burial-transit	cal	resulting in death) Last	Due to (or as	a consec	quence of):									
	P.O. Box 68760	ne death certif the attending thed for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2.5 No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	al death 3	⊒Ectopic   ⊒ Other (s						23d. Date of Month	,	ay Year
	rds, P	quires that the signed by all be detacted	d by Pi	Part II. Other significant conditions confi Acute MI	nbuting to death bu	ut not res	sulting in the u	underlying	cause give	en in Part l		23e. Did to				cause of death?
	Division of Vital Records,	The law requii ite has been s age 2 should	Completed											death	1?	y findings available letion of cause of
	/ita	ding Physicien: The In. After this certificate ha	Be	25. Was case referred to medical examiner?							of Death	(Check only o	-			
	of	Physi this c	. To	1 ☐ Yes 2 ☐ No ☐ Ho	28a Date of Injur		ER/Outpatie			4 🗆 140		ne 5 Resid			pecify)	
	sion	ttending F death. ctor: After / the funer	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day		Injury	М		k? Yes 2 🗍	No					
	-	_ 0	Certif	4 Homicide determined	28e. Place of Injubuilding, etc	: (Speci	( <b>h</b> )					28f. Location (S City or Tox	vn, State	ə) 		
		e Hosp 24 hol e Fune letely fi	Medical	29a. Certifier 1 Certifying Phys. (Check only one)	cian: To the best of er: On the basis of and manner sta	examina	owledge, deat ation and/or in	th occurrence ovestigation	d at the tin n, in my o	ne, date ar pinion, dea	id place, a ith occurre	and due to the old at the time,	cause(s date an	) and manner d place, and c	as state	ed. e cause(s)
		To the Hospitel o within 24 hours aft To the Funeral Di completely filled in	Me	29b. Signature and title of certifier	Lus	ar	)	29	D 2		7			te signed (Mo		
		1530 <b>6</b> .00		30. Name and address of person who cor	npleted cause of de	eath (Iter	m 23a) (Type,	, Print)	D2.				2-	2-20	007	2. 0.00
		Sta	ate.	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	A dature	KliN	S	ARE	DR.	Ball	The	ONE	Ma	1 3/137
		Regist		FFR 0 9 2004	Fla.	1.0	Acres !!	,								

			For 1_ State	State of Mary	•					2	nnl.	03556
_			Registrar		Ce	rtificate	e or L	Jeam	2. Date of Dea	eg. No. 👇	UU÷	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, I		HUNG				Month	Day	Year	06 / 0 M
	/Medic				7.046	T 01	<b>*</b>	1	Leb	1 20	ty of Death	06 70
	Examin	er	4a. Facility Name (If not institution, g Laurel Regional			1	rown, or ire1	Location of Deat	ın		ce Geo	raa
					yrs. last birthday)	If Under		If Under 24 Hrs	8. Date of Birth			
	Funeral Director		579-04-8837	15XM 2□F 87	Yrs.	Months	Days	Hours Min.	8. Date of Birth (Month, Day July 7,	1916	Can	place (State or Foreign ntry) nbodia
			Usual Residence of Decedent						F J . ,		1	
	yland		10a. State 10b. County	10	c. City, Town or Lo	ocation					1	10d. Inside City Limits
	a-f s	ctor	MD Montgo	mery	Silver S	Spring	3					1 Yes 2 □ No
	or 28	<b>Funeral Director</b>	10e. Street and Number			10f. Zip	Code			0g. Citizen of	f What Cour	ntry?
	23a	a	12301 Blakely Co	urt,			20904				SA	
	r deg	ne l	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ace - Americ ack, White,	
36	or the	Ϋ́	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2	2 No	Specify:		Spec	ity: Asi	Lan
8	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Hems 23a or 28a-f show of other than "natural", or Hems 12a or 28a-f show event, the Medical Exacting rulal be notified at	Completed by	15. Decedent's		16a. Dece	dent's Usua	al Occupa	ation		16b. Kind of	Business/In-	dustry
5	in 72	ojet	(Specify only highest	grade completed)	(Give	kind of wor DO NOT us	rk done d	turina most of wo	orking			,
Maryland 21215-0036	with jiene	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4+	Archit	tectur	ral A	Artist		Inde	epende	ent
b	illed Hygie other	BeC	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle,	Maiden Suma	ame)	
lar	Aental Aental rked c	To B	(Unavailable)					(Unav	ailable)		7	
ary	2 should be and Mental is marked a	Γ.	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address	(Street a	and Number or R	ural Route Numbe	r, City or Town	n, State, Zip	Code)
	교통하루		Kan Phung / Son					Court,	-			Land 20904_
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		20b. Place of Dispo cemetery, cre	osition <i>(Nan</i> matory or o	ne of ther plac	θ)	Date	20c. Location	1 - City or To	own, State
Ĕ	Pag ment ant: I ury o		`4 □Donation 5 □Other (Spe		Balt/Wash				7/2004 _			
Salt	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lic	Stowart Mo	132(/				Fleck Fu			
	70 E 2 9	NY. 17							Road, La		Maryla	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the ity one cause on each line.	e death. Do not en	ter the mod	le of dyln	1				Approximate Interval Between Onset and Death
	Physician	0	Immediate Cause (Final disease or condition resulting in death)	a.	AS by	ratio	m	I're	in wan ,	7	-	Days
	/Medical Examiner		resulting in death,	Due to (or as a co	onsequence of):							
a de la constante de la consta		1	Sequentially list conditions,	b. Due to (or as a co	onsequence of):			-				
7	nsit	in in	if any, leading to immediate cause. Enter Underlying Cause Urisease or injury									
1	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
760	eath certificate be said attending physician for use as the burial	call		d								
68	tificat ig ph) as th	edi	-									
Вох	h cer endin	N/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		∃Ectopic pr	regnancy				ate of delive	
	deat	sicie	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4☐Pregnant at tim 9☐Unknown		Other (sp				N	Month	Day Year
P.0	at the de by the a stached	Physician/M	9 Unknown						on- Dida			ha annua of dooth?
	res tha signed be det	by	Part II. Other significant condition		ot resulting in the L	inderlying c	ause give	en in Part I.				he cause of death? cably 4 \timesUnknown
ord	w requir been si should	ted	- Severe a									
Vital Records,	S S	Completed	- payent						24a. Was autop	sv	. Were auto prior to co death?	opsy findings available impletion of cause of
E F		ပ္ပ	Prost	atism					1 Tes	2 (C) No	1 🗆 Yes	21 <del>2</del> No
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only of			_
of	Phys this ral dii	-T	1 Yes 2 No	1 x Inpatient 28a. Date of Injury	2 ER/Outpatie		28c. Injury		Home 5 Resid			(y)
on	ding I h. After funer	ţ	Natural 5 ☐ Pending	(Month, Day Ye	ear) Injury	м	Worl	k? Yes 2 □ No				
Division	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Injury		reet, factory	y, office		28f. Location (S	treet and Nun	nber or Rura	al Route Number,
Ω	tal or Attendits safter death.  al Director: At ed in by the fu	Certification;	4 Homicide	building, etc. (	Specify)				City or Tow	n, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune			Physician: To the best of m								
	the H hin 24 the F nplete	Medicai	one)	and manner stated								
<b>\</b>	To To Con	2	29b. Signature and title of certifier	200		290	License	2899	8	29d. Date sign	-O L	udy, redi)
7	1-		/ / / / / /	-, 1-2		- 20	T	~ ^~		1	1	
			30. Name and address of person w  9/0/   31. Date filed (Month, Day, Year)	no completed cause of deat	h (Item 23a) (Type	Print)	KIT	-II /	24.00	mr	207	08
			31. Date filed (Month, Day, Year)	32. Registrar's	Signature	-1-6	2	-11 (2	The state of the s	7-1D		- 0
	St Regist	ate rar	EER 0.9		na la	An.	12. Wal	, :				

(	Randolph 14-00896 IAN		Price Please 1- StatUnpend Items 23: Registrar	Type or Print State of Ma a,27,28a-f per	ryland / Dena	artment of F	Health and M	ental Hyg	_	ible.	03557
	Dhuaiair		1. Decedent's Name (First, Middle, L					2. Date of Dea Month		Yeer	3. Time of Death
	Physicia /Medic		Randolph W. F	rice				Februar	y 02, 2	2004	1740 P M
	Examin		4e. Fecility Name (If not institution, gr	ve street and number)		4b. City, Town, o	or Location of Death		4c. County	of Death	
			2501 Boston Str	et Pier D		Baltimo					
Ŋ	Funeral Director		220-48-3423	GT	(In yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10-30	Year) -1948	Count	ace (State or Foreign try) 'Yland
	pu ,	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	agation				11	Od. Inside City Limits
	a-f ehov	Director	MD n/a		Toc. City, Town or Ed	Balti	more				1⊠Yes 2☐No
	or 28	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	th wit		2501 Boston S	treet			2122	4	USA		
020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-1 show other treumatic event, the Madical Exertings must be notiling at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 □ No If Yes, Give 1 Year or Dates:	Marine	Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	1	ce - America ick, White, e fy: Whi	etc.
5	2 ho	ted	15. Decedent's I	Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of B	lusiness/Ind	ustry
21712	filed within 7 Hygiene. ther then "n ent, the Med	Completed	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+	life.	Carpent		ing	cons	truct	tion
5	Hyg othe	Bec	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle,	Maiden Sumar	ne)	
aud	lenta fenta rked tic ev	To B	Ross W. Price	!			Marve	l R. Sa	ample		
	2 should be and Mental Is marked o	۲,	19a. Informant's Name/Relationship	(Type, Print) sist	er 19b. Maili	ng Address (Street	and Number or Rur	al Route Number	r, City or Town	, State, Zip	Code)
Z	alth a		Bobbi G. Smick	-	225	Osprey	Ct. Ver	o Eeac	h,Flor	rida	32963
sammore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Other (Special Control of Control		20b. Place of Dispo cemetery, crea		<sup>ce)</sup> 2/7	Date / 2004	20c. Location Balt	-City or Tov	
	artm. Forter orter injur		21. Signature of Fun ral Service Lice		2:	2. Name and Addre	ess of Facility JC	seanh N	7201	aino	Tro Du
0	Ded ding		1 Chap		~ 2	63 S. C	onkling	St.Bal	timore	∍,MD	21224
			23a. Part1. Enter the disease, or con shock, or read failure. List on	nplications that caused to y one cause on each line	the death. Do not en	ter the mode of dyli	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Drowni _ a.	ing complica	ting acute	alcohol int	oxication		- 10	8
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	LXammer		Sequentially list conditions,	b	nezes annues un						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Clue to (or ss. s.	consequence of):						
68/60,	sician an burial-tr		resulting in death) Last	Due to (or as a	consequence of):						
. BOX ba	o death certificate be executed ne attending physician and ed for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnanc	у			ate of deliver	y Day Year

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Medical Certification: To Be Completed by Phy within 24 hours after death.

To the Funerel Director: After this certificate has l completely filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition	Drowning complicating acute alcohol intoxication	
١	resulting in death)	Due to (or as a consequence of):	
	Sequentially list conditions,	b. — Due to (or as a consequence of):	
-	Cause (Disease or injury that initiated events resulting in death) Last	c	
1		d	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Da

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed?  1 Nes 2 No 124b. Were autopsy findings availate prior to completion of cause of death?  1 Nes 2 No 1 Nes 2 No
25. Was case referred to medical examiner?  **EXYes 2 \sum No	Hospital:	h <i>(Check only one)</i> ome 5□ Residence 6점Other <i>(Specify)</i> At scen
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	on Found 1nth, Day Yeer) Found 5:300 Work?	28d. Describe how injury occurred subject drowned
3 Suicide 6 Could no 4 Homicide determine	be de Blee of trium At home for the trium of	28f. Location (Street and Number or Rural Route Number, 2501 Boston Street, Pier D

29a. Cértifier (Check only one)

2501 Boston Street, Pier D Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) O.C.M.E. February 03, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jasha Z GI
31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

FEB 0 9 2004

		-	- State Amend Item 28a	State of Mar per Dr.,G828,0	yland / D 02/09/04d	epartmei be Certifica	nt of Heate of De	alth and N eath	lental Hy	giene Reg. No.	200	4 03	3558
F	Physicia	ın	1. Decedent's Name (First, Middle, La	st)	E	a toto c	_		2. Date of De Month	Day	Year	1 1 5 1	of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City	, Town, or Lo	ocation of Death			County of Dea		
3			Sonno Hopk	ing Hea	Dita	<u> </u>	Utim	TUnder 24 Hrs.	0.0-1-10	15	0.5	n/a	
	Funeral Director	-	5. Social Security Number 16. S 219–58–5927	Sex 7. Age ( 1 M 2 K ) F 5	In yrs. last birth	rs. Months		Hours Min.	8. Date of Bir (Month, Da		0	thplace <i>(State</i> ou <i>ntry)</i> Maryla	
		ŀ	Usual Residence of Decedent							2, 13	2121	, , ,	
	death with the Maryland ms 23a or 28a-f show r must be notified at	-	10a. State 10b. County		Oc. City, Town							10d. Inside	City Limits as 2 🔀 No
	the M	Director	MD Har	ford	Whit	e Hall	p Code			10g. Citiz	zen of What C	ountry?	
	3a or		4706 Norrisvil	Le Road		5	1161			U	nited S	States	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?				anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whi		
5-0036	within 72 hours after death with the Marylan liene the majoral results, or items 23a or 28a-1 show the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏹 Divorced	1 □ Yes 2 🕱 No If Yes, Give Year or Dates:		1 🗆 Yes		Specify:			Specify:	White	e
S C	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gr		16a. l	Decedent's Us (Give kind of w	ual Occupations dur	on ring most of work	ing	16b. Kir	nd of Business	/Industry	
121	filed within 72 Hygiene. Ither than *nai	dm	Elementary/Secondary (0-12)	College (1-4or 5+)				d Nurse		Н	ealth (	Care	
N Q	Hyg Hyg ithe	Be Co	17. Father's Name (First, Middle, Las.	)				8. Mother's Nam	e (First, Middle				
lan I	T T T	To B	Charles Potte:	r, Sr.				Catheri	ne F	elli	ng		
Maryland	2 sho and h is ma	1	19a. Informant's Name/Relationship					d Number or Rur					
	s 1 and 2 should of Health and Men Health and Men Hem 27 is marke other traumatic		Charles Potter, 20a. Method of Disposition	Jr./brothe		775 5 . Disposition (Na V. crematory or		Street	#129 L Date		eton. [		0127
itimore,	Pages nent of P ant; If Ite ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	Removal from State		v, crematory`or p_Svc •		01/2	0/04	To	wson, N	1arylar	nd
Bait	permit. Pages Department of Important; If it any injury or o		21. Signature of Funeral Service Lice	nse			Vonle	<sup>of Facility</sup> Ru Road To	ck Tows			,	Inc.
A.	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the	ne death. Do n						ماالا ک	Approxim Interval B	etween
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 500	wach	hiar	Her	north	age			Onset an	Nows
*	Examiner			Due to (or as a	consequence o	or):			4				
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	of):							
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence o	of):		· · · · · · -					
68760,	te be e ysiciar e buri	edical E		d									
_		Medi	IF FEMALE:										
Box	that the death certifed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 gronths?	23c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at ti	Fetal death	3 □Ectopic 5 □ Other (				2	23d. Date of de Month	Day	Year
Р. О.	t the c by the tachec	hysi	9 Unknown	9□ Unknown									
	es gn be	þ	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying	cause given	in Part I.		tobacco u Yes 2[	se contribute t		unknown
S	law requir as been si 2 should	Completed							24a. Was		24b. Were a	utopsy finding	s available
Re	The la	) mo							auto perfe	omed?	death?	completion of	Cause of
ita	iician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Deal					
<b>o</b>	Physic this c	To:	1 ☐ Yes 2 ☐ No  27. Manner of Death		2 □ ER/Out			4   Nursing H	ome 5 Res			ecify)	
O	ding th. Th. tuner	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day	Year) Ir	njury M	28c. Injury a Work? 1 ☐ Ye	s 2 No	202. 200.00		,		
Division of Vital Records,	s Hospitel or Attending Physician: 24 hours after death. 8 Funeral Disector: After this certifica etely filled in by the funeral director,	Certification:	3 Suicide 6 Could not determine	De Class of Injur	y - At home, far	rm, street, facto	ory, office		28f. Location City or To			Rural Route N	umber,
	urs aft ral Di												
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		hysicien: To the best of miner: On the basis of and manner state	xamination and								e(s)
	Mithi To t	Σ	29b. Signature and title of certifier	1 - 10	1	2	9c. License r	number		-	e signed (Mon	0	
7			Jay 1.	Jem, 1	A)	Type Brief	KlS	-000		~ W	may !	18, 30	07
			30. Name and address of person who	915 Kenn	is her	a a l Ma	12-14×	more M.	V 3/3:	24			
	Sta		31. Date files (Month, Day) Year)		's Signature	-	1000 11	-/-/-/					
- 2	Regist	ar		AND A 12 12 12 12 12 12 12 12 12 12 12 12 12	189								

			For State Registrar AM	FND TTFM #	State of	Maryland					Mental Hy	giene Reg. No	2004	03559
	un A	è	Decedent's Nam			G020 2/1	이 아무 되다				2. Date of De	eath		3. Time of Death
	Physici /Medic		Norris	James	Reid						Febru	ary	4,2004	130 P M
	Examin		4a. Fecility Name		ener and num	HOSDI	+a	n	m, or Loc mor	ation of Death	h	1	County of Deat	h
	Funeral Director		5. Social Security I 237-05-		Sex 12XM 2□F	7. Age (In yrs. Ia <b>91</b>	st birthday) Yrs.	If Under 1 You Months Da		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D March	rth ay, Year	9. Birti	hplece (State or Foreign untry) NC
	pur *		Usuel Residence of	of Decedent  10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
٠.	Maryland -f show	ŏ	MD	N/A			altin							1 <b>y</b> Yes 2 □ No
	the 288	rect	10e. Street and Nu				ar cri	10f. Zip Coo	de			10g. Ci	tizen of Whet Co	untry?
	death with the Marylar ms 23e or 28a-f show	<u> </u>	2605 Mt	. Holly	Street	_		212	216				U.S.A.	
	des	Funeral Director	11. Marital Status		12. Was Dece Armed Fo	ident Ever in U.S	S. 13. \	Was Decedent	of Hispar Cuban, M	nic Origin? (S lexican, Puert	pecify Yes or No	0-	14. Race - Ame Black, White	rican Indian,
036	hours after d tural, or Item	þ		rried 2 → Married 4 □ Divorced	d 1 ☐ Yes If Yes, Giv Year or Da	е		1 □ Yes 2 🖾		pecify:			Specify:Bla	
5-0		etec	(Spe	15. Decedent's acify only highest	Education grade completed)		16a. Deced (Give	tent's Usual Oo kind of work do DO NOT use re	ccupation one during	g most of wor	rking	Betl	(ind of Business/ nelhem	Industry Steel
2121	C	Completed	Elementary/Sec 12t		College (1	-4or 5+)		l Work	er					
Norri S Maryland 21215-0036	d ta b	To Be (	17. Father's Name	(First, Middle, La	st) ukn				18.	Mother's Nar	me (First, Middle	e, Maider	<sup>n Sumame)</sup> uk	in
ary	·	-	19a. Informant's N	Name/Relationship	o (Type, Print)		19b. Mailin	ng Address (St	reet and f	Number or Ru	ıral Route Numb	per, City	or Town, State, 2	Zip Code)
	and 2 ealth a n 27 ls		Kirk Sm	ith - C	randson		3509	N. Ch	ildi	ress_	StFla	agst	taff, A	86004
Ked altimore,	Jes 1 of He or oth		20a. Method of Dis	•	□Removal from	State Ce	metery, cren	sition (Name on natory or other	place)	i .	Date	20c. L	ocation - City or	Town, Stete
E G	ment of tant: If it tant: If it		* 4 □ Donation	5 ☐ Other (Spe	(cify)	Mt.		Ceme				Lan	dsdown	e, MD
Ba	permit. Departr Importr any inj		21. Signature of F	AK. 18	emy		<b>Z</b> 5	01 Gwy	ynns	Fall	s PKWy	. В	ral Hor altimo	mes, Inc. re,MD 2121
100.00			23a. Pert1. Enter shock, or he	the disease, or co ert failure. List or	omplications that c nly one cause on e	aused the deeth ach line.	. Do not ent	er the mode of	dying, su	ich as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or conditi resulting in death)	ion	_aArten	osclero	tic C	ardio:	Vasci	clar	Disea	se		Oliset and Dealit
	/Medical Examiner		resulting in county	- 1		or as a consequ								
-	SET 18	e e	Esquentially list of if any, leading to i cause. Enter Und Cause (Disease of	onditions, immediate		drata or as a consequ		_						
XX	outed and ransit	Examiner	cause. Enter Und Cause (Disease of that initiated even	lertying or injury	Atric	al Fib	rillo	ition					Ì	
7	na di ial-t	Exa	resulting in death)	Last	Due to (	or as a consequ	ence of):							
876	ate of chysicia the bur	dlcal			d									
9	ertific ling p	Mec	IF FEMALE:		22a If was out	come of eroces						- 1	1	
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was deceded in the past 13 1 ☐ Yes 2 9 ☐ Unknow	2 months? ! □ No	1☐Live b	come of pregnar irth 2  Fetal ant et time of de own	death 3	Ectopic pregna Other (specify					23d. Date of deli Month	very Day Year
م.	that if	y Ph	Part II. Other sign	ificant condition	s contributing to de	eath but not resu	lting in the u	nderlying cause	e given in	Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	w requires been sign should be	ed by	Hyper	tensi	in						10	Yes 2	□No 3□Pro	obably 4 Hiknown
Reco	The law re ate has bee page 2 sho	Completed	Congest	ive H	eart	Failu	re					opsy ormed?	/ death?	topsy findings available completion of cause of
Ta.	lcian: Th certificate ector, pag	ပိ	25. Was case refe	erred to medical					26	Place of Dea	1 ☐ Yes	2 (1/10	o 1∟Yes	2 □ No
Ξ	yslcian: is certific director,	To B	examiner? 1 Yes 2		Hospital:	npatient 2 🗆 E	R/Outpatien	t 3 DOA	Other				8 Other (Spec	city)
o uo	ing Ph After th uneral	tion;	27. Manner of Dea	ath 5   Pending investiga		of Injury th, Day Yeer)	28b. Time of Injury		Injury at Work? 1  Yes	200111	28d. Describe			
Division of Vital Records, P.O.	2 = E	Certification;	2 Accident 3 Suicide 4 Homicide	6 ☐ Could no	t be 28e. Place	of Injury - At horng, etc. (Specify	me, farm, str				28f. Location ( City or To	(Street ar own, State	nd Number or Ru e)	ral Route Number,
_	Hospita 24 hours Funeral tely fille	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the kaminer: On the band many	best of my know asis of examinati ner stated.	vledge, death on and/or inv	n occurred at the	ne time, d my opinio	ate and place n, death occu	and due to the arred at the time,	cause(s	and menner as d place, and due	stated. to the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature an	d title of certifier	1	Λ		29c. Lic	cense nur	mber	Т	29d. Da	ate signed (Month	n, Day, Year)
	- 3-0		<b>&gt;</b> \\	A Die A ti	Jah	*		86	140	44		2	4/04	
	20		30. Name and add		ho completed caus	e of death (Item	23a) (Type,		and	Gen	oral	Ho	spital	
	Sta		31. Date filed (Mo	onth, Day, Year)	32. R	egistrar's Signat	ure	- Jic	··· / C					
	Regist	rar		FEB 0	9 2004	Dener	a /	9 1	200 A	61				

			For State Registrar	State of Maryla		artment of I			iene •g. No. 2001	03560
	Physici /Medic		1. Decedent's Name (First, Middle, Frances	Anita	Ro	gers		2. Date of Dead Month February	Day Yeer 2, 2004	2:45 A M
	Examir Funeral	er		eet	rs. last birthday)			s. 8. Date of Birth	Prince Granty of Dear	
	Director		577-30-2087  Usuel Residence of Decedent  10a. State 10b. County		79 Yrs. City, Town or Lo			11/18/1	924 Pen	nsylvania  10d. Inside City Limits
	th the Mary or 28a-f sho	Director	Maryland Prince 10e. Street and Number		Forest	ville 10f. Zip Code		1	0g. Citizen of What C	1 ☐ Yes X⊠ No country?
36	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f show he Madical Examinat institutional	by Funeral Director	2615 Timbercre  11. Marital Status  1 Never Married	12. Was Decedent Ever in Armed Forces? d 1 □ Yes 2 ∑ No If Yes, Give		20747 Was Decedent of If Yes, specify Cub 1 ☐ Yes 2☑ No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	USA  14. Race - Am Black, Wh  Specify:	
Maryland 21215-0036	ithin 72 hours ie. ien "naturel", i.Medical Ex	Completed b	3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Busines:	
land 21	id be filed wi ental Hygien ked othar th Ic event, the	To Be Con	12 17. Father's Name (First, Middle, L Thomas Francis		Re	gistered	18. Mother's Na	ame (First, Middle, M nn Marsha		ical
nore, Mary	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Heatth and Mental Hyglene. If itam 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, the Madical Examinatinast by Italias at		19a. Informant's Name/Relationshi Eileen Rogers / 20a. Method of Disposition 文文表示ial 2 □ Cremation	Daughter 200	2615 D. Place of Dispo cemetery, cree	Timberc sition (Name of matory or other pla	rest Dr.	Forestvi	City or Town, State,  11e Mary 1  20c. Location - City o	and 20747 Town, State
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		* 4 □ Donation 5 □ Other (Special Service Line)			ion Cem.  Name and Addre  160 Oxon			Clinton, N as Funeral ill, Maryl	Home P.A. and 20745
	Physician	e n	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line.	eath. Do not ent		ng, such as cardia			Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease on injury that initiated events resulting in death) Last	b. Due to (or as a cons  Due to (or as a cons  c. Due to (or as a cons  d.	sequence of):					
P.O. Box 68	death certif e attending ed for use as	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome of pre- 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	plivery Day Year
Records, P	The law requires that the de rate has been signed by the a page 2 should be detached for	Completed by Pl	Part II. Other significant condition	s contributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	1 Te	n 24b. Were a y prior to death?	o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
Division of Vital	ding Phyaician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner?  1  Yes 3 No  27. Manner of Death 1 Natural 5 Pending 2  Accident investigs			f 28c. Inju	ner: 4 🗆 Nursing		<del></del>	
Divisi	irec irec	Certification:	3 Suicide 6 Could no 4 Homicide determin		t home, farm, str ecify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or R I, State)	lural Route Number,
×	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical E	Physician: To the best of my xaminer: On the basis of exam and manner stated.	knowledge, death ination and/or in	vestigation, in my	opinion, death occ	curred at the time, da	ate and place, and du	e to the cause(s)
	,1	~	29b. Signature and title of certifier	Hoevayn	1 .		28195	2:	9d. Date signed (Mon 02/02/20	
	) Sta	ate	30. Name and address of person w David Gooray N 31. Date filed (Month, Day, Year)	D 1450 Merc 32. Registrar's Si	antile	Lane #:	217 Lar	go, Maryl	and 2077	4
	Regist	ar	FFR 0 S	2004	So p	medi				

			State of M	laryland / Depa				-	JIDIC.	
			For State Of IV State Of IV Registrer	-	rtificate of l			Sea. No. 2	004	03561
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ith		3. Time of Death
	Physicia		Evelyn Anna Sullivan Rob	erts			Feb.	03	2004	7:59pm <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or	Location of Death		4c. Coun	nty of Death	<u> </u>
			322 North Lapidum Rd.			de Grace	,	Har		
	Funeral		4574 0575	ge (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Coun	lace (State or Foreign try) York
	Director		Usual Residence of Decedent	76 Yrs.			03/11/	1927	New	York
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation				10	Od. Inside City Limits
	Mar a-1sh	ctor	MD Harford	Havre d	e Grace					1 ☐ Yes 2X No
	ith the	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Coun	try?
	s 23e	ral	322 North Lapidum Rd.	Everin II C 12	21078		posity Von er Ne	USA	ace - Americ	an Indian
	ter de Iner	Funeral Director	11. Marital Status  12. Was Deceden Armed Forces 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑	No	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	В	lack, White,	
936	ursal	þ	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates		1 ☐ Yes 2X No	Specify:		Spec	eify: Whi	ite
Maryland 21215-0036	within 72 hours after death with the Maryland iene. rthen "natural", or Itams 23a or 28a-f show the Madical Exantrer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Ĝive	dent's Usual Occupa	during most of work	ing	16b. Kind of	Business/Ind	lustry
121	within ne.	Idm	Elementary/Secondary (0-12) College (1-4or	5+)	DO NOT use retired	1)		Elaman		Colonal
2	filled Hygir ther		17: Father's Name (First, Middle, Last)	s lea	acher	18. Mother's Nam	e (First, Middle,	Elemer		School
an	o d d	To Be	Bert Sullivan			Marie L			ŕ	
7	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a			r, City or Tow	n, State, Zip	Code)
	is 1 and 2 should of Health and Meritem 27 is market other traumatic		Boyce M. Roberts- Son	322 N	. Lapidu	m Rd., F	davre de	e Grac	e, MD	21078
ore			20a. Method of Disposition  1 □ Burial 2 MCremation 3 □ Bemoval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	εθ)	Date	20c. Location	n - City or To	wn, State
Ĕ	Pages ment of tant: If its		1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	The second secon				West C		r, PA
Baltimore,	permit. Page Department of Importent: If any injury or once.		21 Signature of Funeral Service Licensee	N Qu.	Name and Address	nith Fund	eral Hon	ne, P.	Α.	
1	102 e G		25a. Part 1. Enter the disease, or complications that cause		3 S. Was				ice, M	
			shock, or heart failure. List only one cause on each	ngestive	Heart	Failu	-			Approximate Interval Between Onset and Death
7	Pnysician /Medical		resulting in death)	s a consequence of):	Harr	70.11				
	Examiner		Sequentially list conditions b.							
	D H	iner		s a consequence of):						
	ecute and trans	Examiner	that initiated events c	s a consequence of):				<del></del>		
760,	tte be executed tysician and he burial-transit	calE	Due to (or a	a consequence on.						
687	# × @	ᄝ	d							
Box	leath certificat attending phy I for use as th	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom		Ectopic pregnancy			23d. D	ate of delive	ry
-	death	Physiclan/M	1 Yes 2 No 4 Pregnant		Other (specify)		-	N	Month	Day Year
P.O.	that the de ed by the a detached i	Phy	9 Unknown			an in Book	220 Didto	haasaaa .aa		e cause of death?
JS,	Se G e	þ	Part II. Other significent conditions contributing to death	but not resulting in the u	nderlying cause give	эп іл Рап І.		es 2 □ No		1
of Vital Records,	w requir been si should	ompieted								
Rec	The law ate has page 2 :	mp					24a. Was a autops perfor	med?	prior to con death?	psy findings available apletion of cause of
tal		င်	25. Was case referred to medical			26. Place of Deat	1 Yes		1 🗆 Yes	2 □ No
Š	Physician: this certific ral director,	To B	examiner?	ient 2 ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing Ho			ther (Specify	)
100			27. Manner of Death 1 Natural 5 ☐ Pending (Month, D	ury 28b. Time of Injury			28d. Describe h			
Sion	Attending r death. ector: After oy the fune	atlc	2 Accident investigation		M 1□'	Yes 2 □ No				
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of I	njury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location (Si City or Town		nber or Rural	Route Number,
	Hospital or 14 hours afte Funeral Dir tely filled in I		29a. Certifying Physicien: To the bes	t of my knowledge, death	a accurred at the time	ne date and place	and due to the o	auso(s) and m	nanner as st	aled
	To the Hospital or within 24 hours afte To the Funeral Dircompletely filled in	Medical	(Check only one) 2 Medical Exeminer: On the basis and manner s	of examination and/or in	vestigation, in my or	pinion, death occur	red at the time, d	ate and place	, and due to	the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date sign	ed (Month, D	Day, Year)
	1		I techo ma	·	D00	158904		2/4	4/20	04
	14		30. Name and address of person who completed cause of		1 -	Guerra	MD >	10.74		
		-	31 Date filed (Month, Day, Year)  32. Regig	Far's Signature	ure de	Grace	110 -	1070		
S-1	Sta Registr		0 0 200k k	Same A	South					
				4.	A Section					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** 2:050M 1) Lest 12001 02 06 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore River View Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 1 M 2 □ F Yrs. 236-32-3718 Director 76 04-19-1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. Int: If item 27 is marked other then "naturel", or items 23e or 28e-f show 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits th end Mental Hygiene. 7 is merked other then "naturel", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director MD Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 500 Kilarney Court U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. MaYes 2 ☐ No f Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 TNo Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry The Monicle Restaurant Elementary/Secondary (0-12) College (1-4or 5+) Bartender 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Bessie Eller John T. Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 500 Kilarney Court, Forest Hill, Maryland 21015 Sandra S. Herlihy, Niece other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/2004 Morganton, NC Burke Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. M01250 7601 Sandy Spring Rd, Laurel, Maryland 20707 Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ormany Medar Dieane year. Examiner Due to (or as a consequence of) Completed by Physician/Medical Examine or Attending Physicien: The law requires that the death certificate be executed ettending physician end for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? ል 1 Yes 2 No 3 Probably 4 Unknown les onie De chrochie slow many 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has b director, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To 1□ Yes 2□ No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital within 24 hours a To the Funeral C completely filled filled Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) D19667 02-07-2004 ll'llearl Tecesarios 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malika Wasseem, M.D. 709 Eastern Blvd. Baltimore, MD 21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFB 0 9 2004 Registrar

m			For Stete Registrar	State of Maryland		rtment of F			giene Reg. No.	LUUL	03563
	* *		1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	y Year	3. Time of Death
	Physicia /Medic		Eugene Charles F	eisig				Januar			6:35 P M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea			County of Deet	h
-			Upper Chesapeake	Medical Center			Air			Harfo	
**	Funeral		Social Security Number     6. S	ex 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hr Hours Mi	n. (Month, Da	v. Year)	9. Birti	nplace (State or Foreign untry)
16	Director		218-22-2397	M. M. Z.	Yrs.			09/26/	1927	Ma	ryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Lo	cation					10d. Inside City Limits
	f sho	ō	MD Harfor	d B	el Air						1 ☐ Yes 2 ☑ No
	the t	Director	10e. Street and Number	<u> </u>	CI 1111	10f. Zip Code			10g. Cit	izen of What Co	untry?
	3a or	<u> </u>	202 Thames Way			21014			тт	S.A.	
	death with the Maryland ms 23a or 28a-f show Final be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Origin?	Specify Yes or No		14. Race - Ame	
စ္	2 should be filed within 72 hours after death with the Marylan and Menth Hygiens. Is marked other than "natural", or items 23a or 28a-1 show sumatic event, the Medical Example from that be inclined at		1 Never Married 2 Married	Armed Forces? 1X Yes 2 □ No If Yes, Give	}	Yes, specify Cuba	Specify:	erto Hican, etc.)		Black, White	e, etc.
Maryland 21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates: WW I	I	•••				Wh	ite
7	72 h	Completed	15. Decedent's Ed (Specify only highest gra		(Give	ent's Usual Occup kind of work done OO NOT use retire:	during most of w	orking	16b. K	ind of Business/I	ndustry
2	within ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)			•		71		G G-
N D	Hygie ther nt,	ပိ	17. Father's Name (First, Middle, Last,		ASS	embly Per		ame (First, Middle		erican (	an co.
and	ntal I	) Be	John Reisig								
2	d 2 should th and Men 7 is marke traumatic	ဥ	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	a Address (Street		e Schutt Rural Route Numb		or Town, State, Z	in Code)
<u>8</u>	d 2 s th an t7 is trau		Dorothy Sue Kim		0						
Ó	of Health of Health I Item 27		20a. Method of Disposition	20b. PI	lace of Dispos	sition (Name of		Date -		cation - City or	
2	Pages nent of int: If It iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	•	Momonia		/07/2004	-	11-1-	Marin 1 - 3
altimore,		11	21. Signature of Funeral Service Licer			Name and Addre					Maryland
Ba	permit. I Departm Importa eny injui		6 90	Canada I			1				l Home, P.A.
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		23a. Part1. Enter the disease, or com	plications that caused the death				<ul> <li>Kingsv</li> <li>ac or respiratory a</li> </ul>		, MD 2	Approximate
Ÿ.			shock, or heart failure. List only Immediate Cause (Final	3 2 4 4 4	.7	1201/41/	1	licario			Interval Between Onset and Death
£.	Physician /Medical		disease or condition resulting in death)	a. Atheroscleroti		diovasc	may c	useuse			
16,	Examiner		S EST TO SAME THE SECOND DAYS ON	10							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):						
	cuted nd ransi	Examiner	that initiated events	c.							
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d							
9	ertific ling p	Mec	IF FEMALE:								
BO O	death certific attending p	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnai	death 3	Ectopic pregnancy	1			23d. Date of deli Month	very Day Year
Division of Vital Records, P.O. Box	res that the de signed by the a i be detached f	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	atn 5	Other (specify)					
۵.	that the ed by detac	h h	Part II. Other significant conditions	ontributing to death but not resu	ılting in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco u	use contribute to	the cause of death?
ds,	uires sign td be	d by						1 🗆	Yes 2	□No 3□Pro	bably 4 🕱 Unknown
CO	w require been sig should b	Completed						24a. Was	an	24b. Were au	tonsy findings available
Re	he law e has ige 2 s	E D						autoj perfo	psy ormed?	death?	topsy findings available ompletion of cause of
a	Physician: The this certificate har al director, page		25. Was case referred to medical				OS Plans of D	1 D Yes	2 No	1 Yes	2 No
5	sicia cert irect	o Be	examiner?	Hospital: 1 X Inpatient 2 □ I	ER/Outpatien	Oth	oc.	eath (Check only of Home 5 - Resi		6 DOther (Spec	26.)
of	Attending Physician: ir death. ector: After this certifice by the funeral director.	-	27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur		28d. Describe			119)
o	nding ith. :: Afte	atlo	1 Natural 5 Pending 2 Accident investigatio		Injury		k? Yes 2∐No				
VIS	Attendi	ifica	3 Suicide 6 Could not be determined		me, farm, stre	et, factory, office		28f. Location ( City or To	Street an	d Number or Ru	ral Route Number,
	s after s afte	Certification:	4   Hornicide	building, etc. (Specify	')			City of 10	wii, State	,	
	Hospit 4 hour Funers ely fille		(Check only 2 X Medical Exal	ysicien: To the best of my knowniner: On the basis of examinat	wledge, death	occurred at the tirestigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the Hospital or Attending Phys within 24 hours alted death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Dat	te signed (Month	. Day, Year)
	H3 H 8		1 45 4 ×	in, D		0.	C.M.E.		Feb	ruary 01	, 2004
	0		30. Name and address of person who		23a) (Tvne						
	1,		LING LI	MID	1.		Street,	Baltimore	e, Ma	aryland	21201
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 9 2	32 Registrar's Signat	Nº A	sele!					

		•	For State Registrar	State of M	arylan	•	artmen ertificat			ınd M	-		04	03564
	Physici	an	1. Decedent's Name (First, Middle, La Roy Daniel	•							2. Date of Death Month	0.	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv						Location o			4c. County o	of Death	
	Funeral Director		213-16-1904	Sex 7. Aç 1 ☑ M 2 ☐ F	e (In yrs. 82	last birthdaj Yrs.	/) If Under Months		If Under : Hours	24 Hrs. Min.	8. Date of Birth Month, Day,	( <del>9</del> 97)	9. Birthp Cour	lece (Stete or Foreign itry) nchester
	Maryland a-f show	tor	Usual Residence of Decedent           10a. State         10b. County           Md.         Carroll			y, Town or I Westm	ocation inster	?					1	0d. Inside City Limits
	th with the 23a or 28a	Funeral Director	10e. Street and Number 39 Kat	e Wagner	Ct.		10f. Zip		1157		10	g. Citizen of W		itry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Wedical Exercise the rolling 1 at	þ	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 If Yes, Give Year or Dates:	,	S. 13	Was Deced If Yes, spec 1  Yes	V	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		k, White,	an Indian, etc. ite
21215-0036	d within 72 ho piene. r then "natur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	(Giv life.	edent's Usua e kind of wo DO NOT us Mason	rk done d	lurina most	of workir		Brick		struction
Maryland ?	12 should be filed within and Mental Hygiene. 7 is marked other then "reumatic event, the Men	To Be C	17. Father's Name (First, Middle, Last Agron I.	Redding							(First, Middle, Midele, Midele, Ke		*	
	and 2 sho lealth and I m 27 is me		19a. Informant's Name/Relationship ( Kathy Baker –	•	200 0	39 K		agner		Wes	Route Number, stminster	. Md.	2115	7
Baltimore,	permit. Pages 1 Department of F Important: If Ite any injury or ot ance.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci  21. Signature of Funcial Service Lice	(y)	c	emetery, cr ler's	ematory or o	ther place Jeme t	ery I	Peb.	10, 200	oc. Location - 6		
Bal	Depa Impo any i		23a. Part f. Enter the disease, or com	elia dt	d the deat	lo lo	Eckh	rdt	Funer	Dr.,	hapel I	ster, M	d. 2	1102 Approximate
760,	Physician /Medical Examiner physician and physician and physician and physician ille physician ille physician ille physician and physician and physician are physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician and physician are physician and physician and physician are physician and physician and physician are physician and physician and physician are	ical Examiner	shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or as	a conseq	uence of):	az	liñ	ld	nfo	nction			Interval Between Onset and Death Orset and Death Office of the Control of the Con
.O. Box 68	The law requires that the death certificate into has been signed by the attending physionage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	□Ectopic pr					23d. Date Mon		ry Day Year
<u>α</u>	quires that the signed by all be detacted	þ	Part II. Other significant conditions	contributing to death I	out not res	ulting in the	underlying c	ause give	on in Part I.				bute to th	e cause of death?
Il Records,		Completed									24a. Was an autopsy perform	ed? pi	rior to cor	psy findings available inpletion of cause of
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2	ER/Outpati	ent 3 DC	Othe	A.F.		(Check only one ne 5 ☐ Residen		r (Specify	·)
Division of	tending leath. tor: After the fune	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be	OB Place of In		28b. Time Injury	М		at i? /es 2 🗆 l	No	28d. Describe how 28f. Location (Stre			l Route Number
Div	itel or A irs after rel Direc led in by		4 Homicide determined	building, e	tc. (Specif	y)					City or Town,	State)		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical		hysicien: To the best miner: On the basis of and manner s	of examina									
	To the within 1	¥	29b. Signature and title of certifier	h. 111.7	- 7	4 : 1	290	c. License		13	290	d. Date signed	(Month,	Dey, Year)
•	V		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type	e, Print)	1 4	544	13	ninster	01/1	40	9
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Sign	18 Faa	le Ko	ad,	W	esta	ninstel	m	7 2/	157
	Regist		FFR 0 9 2004	Sevena	13	P	poeks	/						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HELEN Μ. ROCKWELL FEBRUARY 5, 2004 3:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1818 CEDAR DRIVE SEVERN ANNE ARUNDEL 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛣 F Director 215-28-4249 72 29, 1931 APRIL VIRGINIA Usuel Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL SEVERN 1 ☐ Yes 2 📉 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1818 CEDAR DRIVE or Items 23a 21144 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Item any injury or other treumatic event, the Medical Experiment 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ LEONARD L. FRIES EULA BAUGHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM T. ROCKWELL, SR./HUSBAND 1818 CEDAR DRIVE SEVERN, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State FEB. 9. CROWNSVILLE MD. VET. CEM. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE, MD 2004 ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee once. KTRKTEY ANDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a / ar onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit ZA that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months?
1 Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached the Ö 9 Unknown 9 Unknown ģ م signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 21 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 🔀 No 1 Inpatient Residence 6 Other (Specify) Medical Certification: To 3 DOA 2 ER/Outpatient this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pelli To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 9 2004

**ORIGINAL** 

		•	1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of Heatificate of De			iene <sub>9g. No.</sub> 2004	03566
	Physicia /Medic		Decedent's Name (First, Middle, Last)     SARA		RICE			2. Date of Deat	2 Day 2004 ar	3. Time of Death 7:25 Р м
<i>)</i> -	Examin	er	4a. Fecility Name (If not institution, give s 7121 PARK HEIGHTS 5. Social Security Number 6. Sex	AVENUE		4b. City, Town, or Lo		8. Date of Birth	4c. County of Deat	n nplace (State or Foreign
	Funeral Director		312-22-3217	M 2 7. Age	91 Yrs.		Hours Min.	8. Date of Birth (Month, Day, MAR. 26	,1912	untry) MD
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  MD N/A		10c. City, Town or Lo	cation				10d. Inside City Limits 1 1 Yes 2 □ No
	3a or 28a-	i Direct	10e. Street and Number 7121 PARK HEIGHTS	S AVENUE		10f. Zip Code	21215	11	0g. Citizen of What Co	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at anone.	by Funeral Director		2. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	Ever in U.S. 13. No	Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	ncan Indian,
21215-0036	I within 72 ho iene. r than "natur the Madical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	life. I	dent's Usual Occupation kind of work done during OO NOT use retired)	on <i>iin</i> g mo <i>st of workii</i>	ng	16b. Kind of Business/	MEDICINE
Maryland 2	uld be filed fental Hyg rked other lic event,	To Be C	17. Father's Name (First, Middle, Last) MAYER		SIG	18	8. Mother's Name REBECC			KNOWN)
	nd 2 shou alth and M 27 Is mai		19a. Informant's Name/Relationship (Ty, BENSON RICE / SOI						City or Town, State, Z	ip Code)
Baltimore,	Pages 1 a lent of Hei nt; If item ry or othe		20a. Method of Disposition 1   1   1   1   1   1   1   1   1   1	emoval from State		sition (Name of natory or other place) DB CEMETER			FINKSBURG	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service License	Rund	22	. Name and Address	of Facility SOL	LEVINSO	N & BROS. SVILLE, MD	INC.
\	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	e cause on each lin	10.		such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	cate be executed physician and physician and street transit	Examiner	Sequentially list conditions, Tary, leading to inmodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):					
.O. Box 68760,	e death certifi the attending hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
S, D	quires that the signed by ald be detacl	þ	Part II. Other significant conditions cor	tributing to death be	ut not resulting in the u	nderlying cause given	in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Vital Record		Completed						24a. Was an autops perform	y prior to d	topsy findings available completion of cause of
Vita	Phyeician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 'S No	ospital: 1 □ Inpatie	ent 2 ER/Outpatien	Othor	6. Place of Death	V	e) Ince 6 Other (Spec	ufu)
ion of	ding Ph L. After th funeral	ation: T	27. Manner of Death 1 Phatural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	ry 28b. Time of	28c. Injury at Work?			ow injury occurred	,
Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office	2	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	he Hospitel or in 24 hours afte he Funerel Dir pletely filled in I	edical	29a. Certifier 1 T-Certifying Physical (Check only one) 2 Medical Examination	sician: To the best ner: On the basis of and manner sta	of my knowledge, deatl f examination and/or in ated.	n occurred at the time, vestigation, in my opin	date and place, a lion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	le		29c. License n	umber	2:	9d. Date signed (Monti	n, Day, Year)
	18		30. Name and address of person who co		leath (Item 23a) (Type,	Print) Re	, tentou	٠٠. ٠٠	3 71.3	(
先	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signadre	J. fr	W			

	1	For State Registrar	State of M	aryland / [		ent of H	lealth and	•			0356
Physician /Medical		1. Decedent's Name (First, Middle, Last)  2. Date (Month						2. Date of De Month Febru			
Examiner		4a. Facility Name (If not institution, gi Continuum Care				ity, Town, o kesvi	r Location of Deat	h		county of Deat	
Funeral Director		5. Social Security Number 6. 214-14-2744		e (In yrs. last birt		der 1 Year	If Under 24 Hrs Hours Min.		rth ay, Year)	9. Birt Co	hplace (State or Foreignuntry)  ryland
Maryland -I show		Usual Residence of Decedent  10a. State 10b. County  Maryland Carrol	1	10c. City, Town	or Location	.e					10d. Inside City Limit
after death with the Ma writems 23a or 28a-1 s other must be notified Funeral Directo	2010	10e. Street and Number 7309 Second Ave.			10f.	Zip Code	1784			en of What Co	euntry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland 1 of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at 70 Be. Completed by Funeral Director	20 1 20 1	11. Marital Status 1	12. Was Decedent Armed Forces  1 NYes 2 If Yes, Give Year or Dates:	•		cedent of H specify Cubs	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)		t. Race - Ame Black, White Specify: Wh	
in 72 ho n natura Aedical I	Diction 1	15. Decedent's E (Specify only highest g	rade completed)		Decedent's U (Give kind of life. DO NO	work done	during most of wo	rking	16b. Kind	d of Business/	Industry
should be filed within 72 hours and Mental Hygiene. marked other than "natural", of imatic event, the Madical Exert To Be Completed by	ne Com	Elementary/Secondary (0-12) 8th Welder  17. Father's Name (First, Middle, Last) Frank Sufczinski Sophia Helinski						, Maiden S	Wrought Iron  den Sumame)		
d 2 should in and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship Sharon Beck /	(Type, Print) Niece	1			and Number or Ru	ural Route Numb	per, City or	City or Town, State, Zip Code)	
Pages 1 and 2 nent of Health int: If item 27 inty or other tra	1	20a. Nethod of Disposition  1 Burial 2 Cremation 3  14 Donation 5 Other (Spec	☐Removal from State	20b. Place of		Name of	-	, Elders Date 7-04	20c. Loca	arg, Md. 21784  Oc. Location - City or Town, State  Balto., Md. 21224	
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Scotice Lice		MOUR	22. Name 27.41	and Addre	ss of Facility hton-Mat w Spring	thews Fi			
sath certificate be executed  x x x x attending physician and corruse as the buriat-transit clan/Medical Examiner	200	Immediate Cause (Final disease or condition resulting in death)  Secreptially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of a consequence of	(e)	30	=a;10	5			
0 0 0		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Tegnant at time of death 5  Other (specify) 9  Unknown							23	23d. Date of delivery Month Day Year	
requires that the seen signed by the hould be detache etect by Physeselect by Physics By Physeselect by Physics Physics By Physics Phys	600	1 2 2 1 1 1								use contribute to the cause of death?	
The law ate has the page 2 s								24a. Was auto perfe 1 \(\sum \) Yes		prior to death?	itopsy findings availab completion of cause o
certifican rector	2	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hagaital:				ath (Check only one)  lome 5 Residence 6 Other (Specify)			cify)	
After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)  28b. Time of Work?  Injury  M 1 Yes 2 No				28d. Describe how injury occurred				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street City or Town, St.						(Street and wn, State)	at and Number or Rural Route Number, State)		
the Hosp in 24 hou the Funer apletely fil		(Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination and	d/or investigat	ion, in my o	pinion, death occu	e, and due to the urred at the time,	date and p	lace, and due	to the cause(s)
To t Com		29b. Signature and title of certifier	RVier	sol,	M	29c. Licens	) / C ) [	5	29d. Date	signed (Mont)	n, Day, Year)
4		30. Name and address of person who	completed cause of	death (Item 23a) (	Type, Print)	2	NIG	عوله	070	1915	YOU
State Registrar		31. Date filed (Month, Day, Year)  FFR 0 9 2	10	rar's Signature	4 1	long in	:/				

			r icase r	•	Department of Health a	•					
			For State				2004 11.1568				
			1. Decedent's Name (First, Middle, Last)	R FH G828 2/12/04 J	HCertificate of Death	2. Date of Death	J. No. 3. Time of Death				
	Physicia	an	Rahack I	92 201:12		Month	Day Year				
	/Medic	_	4a. Facility Name (If not institution, give si	treet and number)	4b. City, Town, or Location o		4c. County of Death				
	Examin	er	- 111	" - "	Rosedale		BAITI MORE				
-	Funeral		5. Social Security Number 6 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year If Under 2						
	Director		220-12-7954 14	M 2 F 74	Yrs. Months Days Hours	Min. (Month, Day, )	29 Maryland				
	p .		Usual Residence of Decedent								
	how		10a. State 10b. County	10c. City, Tov	vn or Location		10d. Inside City Limits 1 ☐ Yes 2 1 No				
	ith the Marylar or 28a-f ehow	Director	IND HAKEFOR		corest ttill		. \				
	death with the Maryland ms 23a or 28a-f ehow	吉	10e. Street and Number	1 6	10f. Zip Code	100	g. Citizen of What Country?				
	s 23s	rai	1 Colgate DY	Was Based on Francis U.S.	21050	sin 2 (Consider Veneza No	14. Race - American Indian,				
	ltem	Funeral	11. Marital Status 1  1 □ Never Married 2 Married	<ol> <li>Was Decedent Ever in U.S. Anned Forces?</li> <li>Yes 2 □ No</li> </ol>	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	Puerto Rican, etc.)	Black, White, etc.				
900	If, or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White.				
ş	be filed within 72 hours after death with the Maryla. Ital Hygieins did the state of other then "neturel", or items 23a or 28e1 ehow event, the Macifical Examinat must be confilled at	ted	15. Decedent's Educ	ation 16a	a. Decedent's Usual Occupation	16	Sb. Kind of Business/Industry				
2	hin 7:	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	of working					
7	d with	ĕ	10	yl	lachinist	K	sethlehem Steel				
D	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		18. Mothe	r's Name (First, Middle, Ma	aiden Surname)				
<u>a</u>		٥	J. Newton J.	m185	Ku	th Wilbu	r.				
<u>a</u>	2 sho and le ma euma		19a. Informant's Name/Relationship (Typ	pe, Print) 19	b. Mailing Address (Street and Numbe	r or Rural Route Number, (	City or Town, State, Zip Code)				
≥ `	s 1 and 2 should I Health and Mer Item 27 le marke other treumatic		Virginia L. Stil	es 1	Colgate Dr. F	ocest Hill,	MD 21050				
0	0 0 I		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	comet	of Disposition (Name of ery, crematory or other place)	Date 20	Oc. Location - City or Town, State				
e E	Pa men ant: ury		' 4 ☐ Donation 5 ☐ Other (Specify)	Moade	swridge Men. tark	2-10-04 I	excidge, MD				
galti	permit. Depart Import any in		21. Signature of Funeral Service License	°h 10	22. Nam and Address of Facility	DEWPORT DE	FORUST HILL, MD				
	20 E # 9		Jun Derly a.	The Holder	EVANS FUNERAL	CHAPEL-BEI	AIR, P.A. 21050.				
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. Do cause on each line.	not enter the mode of dying, such as	cardiac or respiratory arres	t, Approximate Interval Between Onset and Death				
	Physician		Immediate Cause (Final disease or condition	Sepsis			Orisis and Death				
	/Medical Examiner		resulting in death)	Due to (or as a consequence	The same and the s		1				
			Sequentially list conditions, b.	b. METASTATIC CANCER OF UNKNOWN ORIGIN Dus to for as a consequence of.							
	nsit	Examiner	in any teauling to immediate cause. Enter Underlying Cause (Disease or injury	223 10 (0) 43 2 3011034231100	31).						
-	xecu al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):						
9	te be executed ysician and te burial-transit	calE									
89	<u>w</u> = w		0.								
žog	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	• 55		23d. Date of delivery				
	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year				
j.	t the by th	hys	9 Unknown	9 Unknown	···						
ω̂ Σ	The law requires that the death certifical tee has been signed by the attending phy agge 2 should be detached for use as the		Part II. Other significant conditions conf		, ,	23e. Did toba	cco use contribute to the cause of death?				
Vital Hecords,	equire en sig	ed	CCAGUlopAThy	ATRIAL FIBRL	llaTion	1 🗆 Yes	2 ⊠No 3 Probably 4 Unknown				
ပ္လ	aw re	plet	DM			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
ř	The lav	Completed by	Throm bocy Top	10.44.4		performe	death?				
<u>e</u>		Bec	25. Was case referred to me lical		26. Place	of Death (Check only one)					
	Physic this ce al direc	To	examiner? 1 □ Yes 2 □ No	ospital: 1 Inpatient 25 ER/C	utpatient 3 DOA Other: 4 Nu	rsing Home 5 🗆 Residen	ce 6 Other (Specify)				
o c	ng Pt tter tt neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b.	Time of 28c. Injury at Injury Work?	28d. Describe how	injury occurred				
<u> </u>	endir sath. or: Al	atle	2 Accident investigation		M 1 ☐ Yes 2 ☐ N	No					
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)				
	To the Hospital or Attending Physician: whin 24 hours after death this certific To the Funerel Director: Attent his certific completely filled in by the funeral director.										
	Hoep 14 hou Fune Fune	ical	(Check only 2 Medicel Examin	er: On the basis of examination a	ge, death occurred at the time, date and not/or investigation, in my opinion, deat	d place, and due to the cau h occurred at the time, date	se(s) and manner as stated.  a and place, and due to the cause(s)				
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number	290	I. Date signed (Month, Day, Year)				
	F 3 F 8		1 (/. /	1/ MJ	D5588		2/8/14.				
	25		30. Name and address person who con	n leted cause of death (Item 23a)			-13/07				
	1		D. T. 1111 000	o FRANVIII C	QUARE DR. BAL	Timno = M	1 21237				
	V		DR JACKERA 700	U + D R M C I I M Q	YUAKE UKI UMI	II MUNG M	61 X 1 6 U /				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	6						

			For State Registrar				Departme	nt of H	ealth and	Mental Hy	giene 2	004	03569
	Physic		1. Decedent's Name		st) IMONS					2. Date of D Month	_	Year ZCCH	3. Time of Death
	/Med Exami		4a. Facility Name (In	(	e street and number	-1	4b. City	, Town, or	Location of Dea	th (		inty of Death	1
			Marylan  5. Social Security N		neral t	OS pito	to to	r 1 Year	If Under 24 Hrs	8. Date of B	idh	N/A	Palaca (State or Foreign
	Funeral Director		247-17-32		1 ☐ M 2 🛣 F	80	Yrs. Months		Hours Min	JAN.	irth 7, 1924	Col	nplace (State or Foreign untry)
	p ,		Usual Residence of 10a. State	Decedent			own or Location						10d Incide City Limits
(.)	the Marylan 28a-f show	ō	MD	10b. County	Δ	Toc. City, 14	BALTIMO	) T					10d. Inside City Limits 1 X Yes 2 No
$\mathcal{H}$	the M	Director	10e. Street and Nur					p Code			10g. Citizen	of What Co	untry?
Li	th with 23a or	aiD	1517 LE	SLIE STR	EET			2	1217			TICA	
5770	er dea tams	Funerai	11. Marital Status		12. Was Decedent Armed Forces	?	13. Was Dec			Specify Yes or N no Rican, etc.)	0- 14.1	Race - Amei Black, White	
0	1215-0036 within 72 hours after death with the Marylandene then "natural" or Items 23e or 28e-f show the Maryland Exemiter must be natified at	by F	1 ☐ Never Marri 3 ☐ Widowed	ed 2 Marned 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No.	1 ☐ Yes	2 No	Specify:		Spe	ecity: BLA	CK
V	5-0036 72 hours aft natural; or		(Soec	15, Decedent's E	ducation	10	6a. Decedent's Us	ual Occupa	ition	nduna	16b. Kind o	f Business/I	ndustry
	Me dithin	Completed	Elementary/Seco		College (1-4or	5+)			uring most of wo	nang			
5	N 955	e Co	17. Father's Name	(First, Middle, Last	)		DOMEST	1	18. Mother's Na	me (First, Middle		SEWORK name)	
Ò	laryland 212 2 should be filed withi and Mental Hygiene. Is marked other than aumatic event, the M	To Be	HOLLIE	PROCT					MARY M				
SIMMONS	Baltimore, Maryland semit. Pages 1 and 2 should be file bearinment of Health and Mental Hy mportant: If Item 27 is marked oth my injury or other traumatic event and a		19a. Informant's Na				9b. Mailing Addres				-		ip Code)
र	s 1 and s 1 tem 27 other tr				S KEELS/DA	70			ST., BA	LTIMORE Date			
H	DOF ages 1 nt of th t: If ite	1		Cremation 3	Removal from State	ceme	of Disposition (Na Itery, crematory or	other place	·		20c. Location	·	
<b>V</b> )	Baltim permit. Pag Department Important: any injury once.		21. Signature of Fu	5 Other (Special Notice Lice		ARB	UTUS 22. Name a	nd Addres		2/2004 MES A.	BALTIN MORTON		S F.H., INC
	Deparation of the control of the con	1	a	mes C	Lofu. L	Lon				, BALTO			2
			23a. Part . Enter the shock, or hea	ne disease, or com nt failure. List only	plications that cause one cause on each	d the death. D	o not enter the mo	de of dying	, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause ( disease or condition resulting in death)	(Final n	a. UNC	Xic	LA	cer	phalo	path	4		Onset and Death
	/Medical Examiner		rosening in douin,		Due to (or as	s a consequenc	ce of):	1		,	)		
	4,00	Jer	Sequentially list confi any, leading to imcause. Enter Under Cause (Disease or that initiated events	nultions, nmediate	Due to (or as	s a consequen	ce of):						
	60, be executed sician and burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) to	injury	c								
	760, te be ex ysician a	cai E)	Todaking in ocality (		Due to (or as	s a consequenc	ce of):						
	9 % 9				_ d	-							
	vision of Vital Records, P.O. Box 68 Attanding Physician: The law requires that the death certifica redeath. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent		23c. If yes, outcome	e of pregnancy 2  Fetal dea		pregnancy				Date of deliv	•
	b.O. E	sici	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnant a 9□ Unknown			pecify)				Month	Day Year
	Division of Vital Records, P.O. or Attanding Physician: The law requires that the differ death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	Phy			contributing to death I	but not resultin	g in the underlying	cause give	n in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
	rds, quires n sign uld be	d by								1 🗆	Yes 2□No	3 Pro	obabiy 4 Unknown
	ecord aw requir ts been si 2 should I	Completed								24a. Wa		b. Were aut	opsy findings available
	The I	Com					, , , , , , , , , , , , , , , , , , , ,			perf	ormed?	death?	ompletion of cause of
	Vital Rec sician: The law certificate has b irector, page 2 s	Be	25. Was case references		Hospital:			Otho		ath (Check only	one)	-	
	Phys Phys	2	1 ☐ Yes 2 ☐ 27. Manner of Deat		28a. Date of Inj		Outpatient 3 D	OA Othe 28c. Injury	4   Nursing	Home 5 ☐ Res 28d. Describe			ify)
	ion or nating I	atlon	1 Datural 2 Accident	5 Pending investigation	(Month, Da	ay Year)	Injury M	Work	? ′es 2⊡No			551100	
	VISIO	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Flace of In	ijury - At home,	farm, street, facto	ry, office	-		(Street and Nu	mber or Rui	ral Route Number,
.\	Hospital or 24 hours affe Funeral Dir tely filled in			/						1			
by	Division  To the Hospital or Attano within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exa	nysician: To the best miner: On the basis of and manner s	of examination	lge, death occurre and/or investigatio	at the time on, in my op	e, date and plac inion, death occ	e, and due to the urred at the time	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
_	To tha within 2 To the comple	₩	29b. Signature and	title of certifier			29	c. License	number		29d. Date sig	ned (Month	, Day, Year)
			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2W_	(House	Staff		289	5060		Februa	scu !	474 S
	3	)	30. Name an add	s o person who	completed cause of	death (I em 2/3	1 A -	1.	0		1 11		LI
	W 194		31. Date filed (Mon	n. Day Yearl	nick Mi	rans Signature	) Mary	land	2 Die	mera	14	OSPI	19/
	Regis	tate trar		EB - 9 20	267	A	Anne.	7					
	DHMH 17 Rev 1/	2001		46.		65 35	2						
						0	RIGINAL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician EVA** SHANKLIN FEBRUARY 8 2004 12:40 A. ELIZABETH /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 💆 F <u> April</u> 9, Maryland 1914 Director 89 <u>214-07-4308</u> Usual Residence of Decedent the Maryland 10d, Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar most be notified at 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with S. A. 517 Riverside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: à 3X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) in and 2 should be filed within Health and Mental Hygiene. Own Home Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brotemarkle Nellie Pearl Michael Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if item 27 is eny injury or other tra Abingdon, Maryland 21009 2720 Merrick Way (Daughter) <u>Jacquelin Barnes</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 2/11 2004 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Belair Memorial Gardens Harford, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ueab me disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner u to (or as a cons uun e of) attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) signed by the at id be detached fo P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 2 1 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Attending Division 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide ŏ To the Hospital t Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m eted caluse of death (Item 23a) (Type, Print) 30. Name and address of person who NWE) Mar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2001

			Certificate of Death	Reg. No.	004 03211
П	Physicia	DeCedent's Neme (First, Middle, Last)		2. Dete of Deeth Month Day	3. Time of Death
200	Physicia /Medica			Month Day	04 200
	Examine	An English blomme (Manager to add and a second at a se	4b. City, Town, or	Location of Deeth 4c. Cou	nty of Deeth
		Manor Care Kossvill		ville	Baltimore Co.
	Funeral	5. Social Security Number 6. Sex 1 M 2 Age (In yrs.	Months Days Hours Min		Birthplace (State or Foreign Country)
	Director	213=12-4332 90	Yrs.	Jan. 20,1914	
	and	Usuel Residence of Decadent  10a. Stete 10b. County 10c. City	y, Town or Location		10d. Inside City Limits
	f sh				1 ☐ Yes 2√5 No
	the 28s	Maryland Baltimore  10e. Street end Number	Dundalk  10f. Zip Code		of What Country?
	A Sa Sa			_	
	72 hours after death with the Maryland naturel', or items 23a or 28a-f show sical Examiner must be notified at	8103 Longpoint Road  11. Maritel Status  12. Was Decedent Ever in U, Armed Forces?  1   Never Married 2   Married   1   Yes 2   No	S. 13. Was Decedent of Hispenic Origin? (		ed States Raca - American Indian,
0	the result of th	Armed Forces?  L 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	S. 13. Was Decedent of Hispenic Origin? (	to Rican, etc.)	Black, White, etc.
8	Murs a		1 ☐ Yes 2 ☒ No Specify:	Spe	cify: White
9	n 72 hours natural;	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondery (0-12)  6 Years  If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grede completed)  College (1-4or 5+)	16a. Decedent's Usual Occupetion	16b. Kind of	Business/Industry
2	within ene.	(Specify only highest grede completed)  Elementery/Secondery (0-12)  College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	rking	
7	filad with Hygiene. ther than	6 Years	Homemaker	Ow	n Home
Maryland 21215-0020	be filad tel Hygi d other event,	17. Fether's Neme (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sum	ame)
yla	should be nd Mantel marked o umatic ever	Joseph Martin	Mary N	emethy	
<u>a</u>	2 sh end end end end	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or R		
<u>√</u>		Michele C. Barnes / Daughter	821 50th Street Du	ndalk, Marylan	d 21222
9	S o E E	20a. Method of Disposition 20b. Pl  Y□ Burial 2 □ Cremation 3 □ Removal from State	ece of Disposition (Name of ametery, cremetory or other place)	Date 20c. Locatio	n - City or Town, State
E	permit. Pages Depertment of I important: If Ite any Injury or of once.		cred Ht. of Jesus Cem.	2/9/2004 Du	ndalk, Maryland
Baltimore,	pemit. Pa Depertmar important: sny Injury ance.	21. Signeture of Juneral Service Licensee	22. Name and Address of Facility Duda-Ruck Funera	Home of Dund	alk Inc
	70 F 9 9	Degan Elan		Dundalk, Maryl	
	2	23a. Peri 1. Enter the disease, or complications that caused the deeth shock, or hear failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between
	Physician				Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition	YPOXIA		
		resulting in death) e	as a consequence of):		HOURS
	sit ed	b	NEUMONIA		
_	certificate be executed ding physician and isa as the bunal-transit	Sequentially list conditions, if any, leading to immediate	as a consequence of):		
09	be e ician buna	cause. Enter Underlying Ceuse (Disease or injury			
Box 68760,	phys s the	that initiated events resulting in death) Lest Due to (or	as a consequence of):		
	nding usa s	d			
ă	es that the death of igned by the attanbe datached for u	Double Other classificate and tales and the control of the control			
7. Ö.	the cay the ache	Part II. Other significant conditions contributing to death but not result	iting in the underlying cause given in Part I.		ontribute to the cause of death?
Ţ	s that			1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
ğ	Attending Physician: The law requires that the death refeath.  ctor: After this cartificata has been signed by the attactor. After this cartificata has been signed by the death of the funaral director, paga 2 should be datached for the funaral of the Completed by Physicial	CONGESTIVE HEART	Ta 12 05	24a. Wes an autopsy	24b. Were autopsy findings
ပ္ပ	s bee	WNOEST IVE HOSEL	PATILUKE	performed?	available prior to completion of cause of deeth?
ř	he la a ha aga 2			1  Yes 2  1√No	1 Yes 2 No
<u> </u>	artificat actor, p	25. Was case referred to medical	26 Please of Dec	ith (Check only one)	TLI FOS ZLINO
>	hysici his car il direc To B	exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 E	Othor	ome 5 ☐ Residenca 6 ☐O	ther (Specify)
Division of Vital Records,	g Ph erth narai	27. Menner of Deeth 28e. Date of Injury (Month, Dey Year)	28b. Time of lnjury at Work?	28d. Describe how injury occi	
0	ath. r:Aff	1. ☐Naturel 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	M 1 Yes 2 No		
5	I or Attendi attar death Director: A d in by the f	3 Suicide 6 Could not be determined 28e. Plece of Injury - At hor building, etc. (Specify)	ne, farm, street, fectory, office	28f. Location (Street and Num City or Town, Stete)	nber or Rural Route Number,
בֿ	ital or its after all Dir led in Cert	Saliding, see. (openly)		o., o. 10mii, olele)	
*	To the Hospital or Attending Physician: The law within 24 burors after death.  To the Funeral Director: After this cartificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Comm	29a. Certifier (Check only  one  1 ☐ Certifying Physician: To the best of my know 2 ☐ Medical Examiner: On the basis of examination	ledge, death occurred at the time, date and place	, and due to the cause(s) and n	nanner as stated.
\	within 24 To the F complete	one) and manner stated.			
	So d with	20	29c. License number		ed (Month, Day, Year)
	.1	John 10	DS1306	FEB S	2000
	Ŋ	30. Name end address of person who completed cause of deeth (Item :		eff. CTP	/
- 62		DENNIS H - ODIE 1232 FACE FO 31. Date filed (Month, Day, Year) 32. Registrar's Signetu	7	MD 21237	
	State Registrar	0 0 0000	H And Do		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month
February 1, 200.
4c. County of Death **Physician** DOUTHALL 8:20PM ARYANA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Center Greater Bottomore Medical Towson 8. Date of Birth
(Month, Day, Year)
January 6,2004 If Under 1 Year If Under 24 Hrs.
Months Days, Hours Min. Birthplace (State or Foreign Country)
 A A A 5. Social Security, Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No £55ex KALTIMORE MD Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? U. S. A 1108 21221 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: 1□Yes 2☑No 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NEVER WORKER N A NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rywell SouthALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mo SUTTON ESSEX 21221 1108 TACK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition → Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 104 OAKLAUN CEM. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HARTIEY Miller RD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** rematu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death tilled in by the tuneral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Monknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 🗆 No Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Medical Certification: To 1 NInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier mpletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature title of certified 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

-		and the last		
	5	Long	-7	-
U	U	1	1	1

					Cer	tificate of	Death	Re	g, No.	104 (	10010
	Discosioni		1. Decedent's Name (First, Middle, Last	t)		_	1 1	2. Dete of Deetl	n Day	Van-	Time of Death
	Physici /Media		Ashley	LYN	N	<u> </u>	elander	Febru		2004 10	2:05AH
J.	Examir		4e Facility Neme (If hot institution, give	street end number)			4b. City, Town, or Lo	ocation of Death	4c. County		
			Johns Hopkir	is Hosp	I+AL_	W11-1-1-1	BAltin	roke Lity		NIA	
	Funeral Director		5. Social Security Number 6. Se 10 11 12 19 19 10 10 10 10 10 10 10 10 10 10 10 10 10	9X 7. Age (Inlyrs	21 (21)	If Under 1 Year Months Days	Tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, MAY 31	Year) 1982	9. Birthplace Country)	(State or Foreign
	land		10a. Stete 10b. County	10c. C	ity, Town or Loc	cation				10d. lr	nside City Limits
:	May Har	to	MD. N/A		BALTI	MORE				1	Tyres 2□ No
	1 28 H	Director	10e. Street end Number			10f. Zip Code		10	g. Citizen of	What Country?	
	1 wit		3507 DILLON STREE	$\mathbf{T}$			21224		U.S.A		
	dea Ger	Funeral	11. Meritel Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. W	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Rad	ce - American In	dian,
0020	72 hours after death with the Maryland natural, or flems 23a or 28a-f show dical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		□ Yes 2 No	Specify:	rnoan, etc.)	Specif	ck, White, etc. y: WHITE	
21215-0020	within 72 hours ene. than "natural", he Medical Ext	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16e. Deced (Give k life. D	ent's Usual Occup kind of work done O NOT use retired	eation during most of work d)	ing 1	6b. Kind of B	usiness/Industry	,
	0 0 =	ρÖ	SPECIAL EDUCATION		NEVE	R WORKED	)		N/	'A	
nd .	al Hy	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name			10)	
yla :	should be nd Mental marked o imatic eve	ို	UNKNOWN				MELISSA	SELANDE	CR		
Σ̈́	end 2 sh ealth end n 27 is m		19a. Informant's Name/Relationship (Ty MELISSA SELANDER)	/MOTHER	3507	DILLON S	and Number or Rure TREET, BA				
Baltimore,	reges I nant of H int: if iter iry or oth		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify)	Removal from State BA	Place of Dispos Cemetery, Crem LTIMORE CREM	ition (Neme of atory or other plac WASHING IATORY	TON	Date 2 2/9/04 I		City or Town, S	
Balt	Depenting Depending Imports any injury injur		21. Signature of Funeral Service License	99	22.	Name and Address		ARLES S.	ZEILE	R & SON	, INC.
			23a Part 1 Enter the disease or compli	ications that caused the dea	///						
- del	hysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.	in. Do not ente	Title mode or dyin	ig, such as cerdiac c	or respiratory erres	ы,	Inter	oximate val Between et and Death
A 4	/Medical		Immediate Cause (Final	Re soil	Lance	Carlo	ico.			1	1
E. E	Examiner		disease or condition resulting in death)	Due to	Or as a consequi	POUTO	10	. 1			LAYS
/	n .#	ner		Atoleat	71 Cic	Dow	Conas	lidati	DVΩ	31	pote
	incate be executed ig physicien and as the burial-transit	Examiner	Sequentially list conditions,	Due to (	or as a consequ	ence of):	1	11-1-001		200	1
x 68760,	cien g	Ē	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Severe mi	red (	entra	And Or	2struct	rive the	ONEL 8	years
68760,	physi the !	edicai	that initiated events resulting in death) Last	Due to (c	or as a consequ						2/ UPPES
9 X 6	S G S	₹		Spina P	Sixido	- ARNOLO	d-Chian	Malson	mation.	Hyderces	halus
C3 '	aften for u	clan				1.			7	10,07	781
, P.O. B.	bean signed by the atten should be datached for u	Physician	Pert II. Other significant conditions con	tributing to death but not res	sulting in the und	derlying cause give	en in Part 1.	23b. Did tob	1	ntribute to the c	auee of death?
<u>ا</u>								1 Tye	21XNo	3 Probably	4 🗌 Unknown
ords	n sign	象						24a. Was an	autopsy	24b. Were au	
eco	S CV	plet						performe	ed?	available completi of death?	on of cause
<u> </u>	ata has	Completed by						1 □ Yes	2 No	1 □ Yes	200
vision of Vita	entific actor,	Be	25. Was case referred to medical examiner?				26. Plece of Death	(Check only one,			
- To	this c	မ	1 195 210 NO	_	ER/Outpatient	3□ DOA Othe	4 Li Nursing Hor	ne 5 Residen			
no Brain	The The	<u>ë</u>	27. Menner of reth 1 Shaturel 5 Pending	28a. Dafe of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurr	ed	
Sic	daath tor: / the /	icat	Accident investigation  3 Suicide 6 Could not be	200 Place of Injury At h			Yes 2 □ No	106 Landing (Oten	-4	0 10	
	s after al Director ed in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	st, ractory, ornos		281. Location (Stre City or Town,		or nural nout	e Number,
To the Hospital or	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edical	29a. Certifier (Check only one)	ician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death o tion and/or inve	occurred at the tim stigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ad at the time, date	se(s) and ma and place, a	nner as stated. and due to the c	ause(s)
Ţ	withir comp		29b. Signature and title of certifier	> 1/1	ine Shoti	29c. License	number	290	l. Date signed	i (Month, Day, Y	(ear)
			D-62	Page P	· Jahren	KE	5-000	)	7/1	5/4	
	1		30. Name end eddress of rerson who con	mpleted cause of death (Item	n 23e) (Type, P	rint)				-	
			Pertick J. Grober	- 600 N. Wel	ta St	Baltino	CL. MO	3/3 87	-		
Algaria	Stat	.6	31. Date filed (Month, Day, Year)	32. Registrar's Signe	ture of						

Please Type or Print in Black Indelible Inks Ensure All Copies Are Legible.

Amend Item #1 per phy 6830 4/28/04 Itas Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Item 1,26 per Dr., G828,02/09/04dbb cate of Death

Reg. No. 2001 Justin Norbert Scharf 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 1103 AM 1) /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosed MASON-Diron Hagestown
If Under 1 Year | If Under 24 Hrs. 18821 WAShinste #, Sex 102 M 2□F Birthplace (State or Foreign Country)
 Unk 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min Months Hours 7426 206 Yrs. 14 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8821 21740 MASIT WXON USA trong Loca 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status unk Black, White, etc. filed within 72 hours after 1 K Yes 2 No If Yes, Give Year or Dates: 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Completed by Specify: 3 Widowed 4 Divorced neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk pemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) Colfege (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Dr. Kotch/Washington Co DME 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

Approxima 21. Signature of Funeral Service Licensee Ronald S. Wade, Director once. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final **Physician** Conn sula disease or condition /Medical resulting in death) Examiner Alellitu 151423 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed burial-transit - portenion that initiated events resulting in death) Last and D e to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? director, page 2 should be 4 Unknown 2 🗌 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner?
1 

Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t the Hospital or Attending 1 Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEFENTY MEDICAL CY+171UFC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UFE 7-46-46 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2004 TOTAL S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death DANTH 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Y M **Physician** SCHWAR 2004. TEBRUARY 2 EVELYN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) APR. 13, 1915 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 88 Yrs. MD 216-10-6096 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State the Medical Examiner must be notified at 1 ☐Yes 2 ☑ No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö U.S.A. 21208 Itema 23a 1601 WOODLING WAY Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2X No Yes, Give 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed by 3 

Widowed 4 □ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental t of Health and Mental **ROTH** SAMET **FSTHER** WOL F FANNIE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1601 WOODLING WAY - BALTIMORE, MD 21208 SHELDON SCHWARTZ / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation permit. Page Department o Important: If any Injury or once. tion Other (Specify)
of uneral Solvice Lipus BETH ISAAC ADATH ISRAEL 2/6/2004 DUNDALK, MD ⁴ 4 □ Donátion 22. Name and Address of Facility 21. Signatu SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA /Medical Due to (or as a consequence of) **Examiner** 3 DAYS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy 1 Live birth ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 Probably 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) ş in a 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mehlo mo T W O inder 46 D0041410 February DY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORINDER P MEHTA CENTER. PURCHITTELL N ML 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Registar's Signature

2004

FEB C Mercus

		1	For State Registrar	S	tate of N	Marylan		rtment			nd M		Reg. No.	edunad describe	035	
	Physicia		1. Decedent's Name (First, N JOSEPH I.	iddle, Last) SCHWAB							:	2. Date of Dea Month	Day	Year	3. Time of 730	
	/Medic	al -	4a. Fecility Name (If not instit		et and numbe	er)		4b. City,	Fown, or l	ocation of		Februar	4c. County	of Death	730	14
	Examin	er		pital a	6 12		re.		ti me		Cit	4	N/A			
	Funeral Director		5. Social Security Number 091-30-1201	6. Sex 1 <b>[X]</b> M	7. /		last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Bin JAN 194	1938	9. Birth	olace (State or ntry)	Foreign
	and and		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or Lo	cation							10d. Inside Cit	y Limits
	Maryl	tor	MD BAL	ΓΙMORE		B/	ALTIMOF	RE							1 🗌 Yes	2X□ No
	death with the Maryland ma 23a or 28a-f ehow r must be retilled at	Funeral Director	10e. Street and Number 4615 HORIZON	CIRCLE	#3			10f. Zip 212					10g. Citizen of USA	What Cou	ntry?	
930	be filed within 72 hours after death with the Marylan Hydjone. Hydjone. All Hydjone. All Hydjone. All Hydjone. See of ehow other than "natural", or itema 23a or 28a-f ehow event, the Medical Examinar must be notified at	þ	11. Marital Status 1    Never Married 2  3   Widowed 4   Divo	Married	Was Decede Armed Force 1 Yes 2[ If Yes, Give Year or Date	s? <b>X</b> No		Vas Deced f Yes, spec		panic Orig Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	Bla	ce - Americk, White,		
9500-61717	filed within 72 hours after Hygiene. sther than "natural", or ite ant, the Medical Examina	Completed	15. Dece (Specify only h Elementary/Secondary (0-		on ompleted) Cottege (1-40	or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done du		of work	ing	16b. Kind of B		dustry	
	id be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Mic	Idle, Last)		SCHW				18. Mothe	r's Name	e (First, Middle,	Maiden Sumar ROSENBE			
la L	and 2 should ealth and Men n 27 is marke ser traumatic	-	19a. Informant's Name/Rela MRS. PHYLLIS				19b. Mailir			nd Numbe		IORE, MD.	er, City or Town	State, Zij	Code)	
ġ,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic. ones.		20a. Method of Disposition  1 Burial 2 Crema  4 Donation 5 Oth	ion 3 🖫 Rem		20b. F	Place of Dispo DAR PAR	sition (Nan	ne of			Date	20c. Location PARAMUS		own, State	
Baltı	permit. Departm Importa any inju		21. Signature of Funeral Ser	vice Licensee	eith	the	89	. Name an 900 RI	d Address EISTE	of Facility RST0	w SOL	OAB PIR	esvile	OSD.	INC 21208	
60,	Physician /Medical Examiner prize prijetransit	cal Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, or any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e, or complicat List only one c	Due to (or	h line.	Encery (uence of):	, ,			cardiac (	or respiratory a	rrest,		Approximation interval Beth Onset and I	ween
. Box 68	death certifica e attending ph od for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230.	If yes, outcon 1 Live birth 4 Pregnan 9 Unknown	n 2 ☐ Feta It at time of c	al déath 3 🛚	]Ectopic pr ] Other (sp						ate of delive		/ear
ds, P.	uires that the de signed by the a id be detached f	þ	Part II. Other significant co	1.	buting to deat		sulting in the u	P	ause give	1			oba¢co use con Yes 2 □ No		the cause of d bably 4 🗀	
Records,	The law requires that the site has been signed by the bage 2 should be detache	Completed	Hypertrophy	, Inter	mitte	1-1	tuss	>	stip	0		24a. Was auto perfo		Were autoprior to codeath?	opsy findings omptetion of c	available ause of
	ien: ] rtifica ctor. p	Be C	25. Was case referred to me	edical					-		of Deat	h (Check only				
ō	Attending Physicien: The lav ir death. ector; Atter this certificate has by the funeral director, page 2	၉	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ P		28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		8c. Injury Work	at			dence 6 Ot how injury occu		fy)	
Divis	• Hospital or Attendi 24 hours after death • Funeral Director; A etely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place of building	Injury - At h , etc. <i>(Speci</i>	iome, tarm, sti fy)	reet, factor	y, office			28f. Location ( City or To	Street and Num wn, State)	ber or Rui	ral Route Num	ber,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: comulately filled in by the	edical C	29a. Certifier 1 Ce (Check only one) 2 Me	tifying Physic dical Examine	ian: To the best and manne	is of examin	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, th occur	and due to the red at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s	s)
	vithin 2 To the	ž	29b. Signature and title of c	ertifier	1			1	. License				29d. Date sign	ed (Month	, Day, Year)	
}	2)		· / A		Ju	no	_		KES	. 60	0		-6 proard	3	2004	+
	00		30. Name and address of po	rson who com	pleted cause	of death the	1 - 1	1	12	11.	_		/			
	Sta	ate	31. Date filed (Month, Day)		32. Reg	pis <b>pa</b> r's Sign	ature To	210]	10	TI	ner	4			- <u></u>	
	Regist			p 0 9 7	2004	Holes.	, K	1	2							

			1 - For State Registrar	State of Marylan		artment of rtificate of			giene Reg. No. 2	004	03577
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last,     JAMES PH      4a. Fecility Name (If not institution, give	ILIP SH	OWERS	4b. City, Town,	or Location of	2. Date of De Month  Janua  Death	ry 2/	Year 2004 ity of Death	3. Time of Death
	uneral	er	Washington Coun 5. Social Security Number 6. Sec	ty Hospital x 7. Age (In yrs.	last birthday)	Hager If Under 1 Year	stown	1	Wa	shing	
D	irector		234-01-9384  Usual Residence of Decedent  10a. State  10b. County	M 2□F 86	Yrs. y, Town or Lo	Months Days	Hours	August 1	(6,1917		ce (State or Foreign Virginia
<b>5-UU.SO</b> 72 hours after death with the Maryland	liem 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	ed by Funeral Director	Maryland Washin  10e. Street and Number  19808 Tranquil  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu	ity Circle  12. Was Decedent Ever in U Armed Forces?  1  Yes, Give Year or Dates:	gerst	0 W N 10f. Zip Code 2 1 7	Hispanic Origon, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)	U.S.	f What Country	1 ☐ Yes 2 ☐ No  y?  1 Indian, c.
G Z I Z I	other than "na ent, the Medic	e Completed	(Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		(Give	kind of work done DO NOT use retire ality	during most od) uperv	of working 'isor 's Name (First, Middle,	Aircr	aft M:	•
ryiai	is marked or raumatic eve	To Be	Philip  19a. Informant's Name/Relationship (T)		OWERS	ng Address (Stree	Flo		ouise	Eugl	
<b>⊆</b> 0 ±	If item 27 is or other trau		Ella Marie Sho  20a. Method of Disposition  1 Burial 2 Cremation 3 F	20b. F	lace of Dispo	sition (Name of	ice)	Circle, Ha	20c. Location	- City or Town	n, State
Daltimo	Important: If item 2 sny injury or other once.		21. Signature of Funeral Service Licens  R. Roof Diz	99 /	Añ	drewark <sup>Addr</sup>	Coffma	01–22–04 n Funeral H Street, Ha	Home. I	nc.	Maryland
be executed	hysician and edical saminer transit the burial-transit	Ical Examiner	23a. Pert1. Enter the disease, or complishock, or heart failure. List only of shock, or heart failure. List only of shock, or heart failure. List only of shock or condition resulting in death)  Saquentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	Due to (or as a consequence to consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):  Uarry uence of):	Fibra	ing, such as d	ardiac or respiratory an	rest,	A In	pproximate nterval Between onset and Death
Geath cert	been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d.  23c. If yes, outcome of pregnate to the control of the contro	Ideath 3	Ectopic pregnanc Other (specify)	:y			Pate of delivery Sonth Da	ay Year
ecords, F.O.	been signed b should be deta	þ	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the ur	nderlying cause g	ven in Part I.		obacco use co ves 2 No		cause of death?
<b>E</b> PE	ate has page 2	Completed						24a. Was autop perfor		prior to compl death?	y findings available letion of cause of
Or Vital Physician:		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ot	bac	of Death <i>(Check only o</i>		ther (Specify)	
VISION OF	tor: After this	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat ork? ]Yes 2 □ N	28d. Describe h	row injury occu	ırred	
DIVISION To the Hospital or Attending	ral Direct	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y)			28f. Location (S City or Tow	m, State)		
the Hosp	To the Funeral Directompletely filled in by	Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	vestigation, in my	opinion, deatl	n occurred at the time, o	date and place	, and due to th	e cause(s)
2 3	200		29b. Signature and title of certifier	2ac		D	se number	7/	1-2.	ed (Month, Da	
V			30. Name and address of person who co	11110 Me	drest	Campa	es Ed	Hog.	Md.	2174	12
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	le .	10	C. 8.				

		For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	rtment of H			ene 200	03578
· · · · · · · · · · · · · · · · · · ·	5	1. Decedent's Name (First, Middle,	Last)				2. Date of Death	1	3. Time of Death
Physici		Lillie	Mav	Stewa	art		Feb.3,	Day Year	4:27
/Medic Examin		4a. Facility Name (If not institution,				r Location of Death		4c. County of Dea	ith
LAGIIII	è	John Hopkins	Hospital		Baltime	ore		n/a	
Funeral			5. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign
Director		212-32-6298	1□M <b>203</b> F	70 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 22,	1933 MD	ountry)
0		Usual Residence of Decedent							
ylan		10a. State 10b. County		10c. City, Town or Los	cation				10d. Inside City Limits
Man Man	Director	MD N/A		Bal <sup>-</sup>	timore				1x Yes 2 □ No
h the	l'e	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
death with the Maryland ms 23a or 28a-f show finant be notified at		1105 N. Ken	wood Ave	•	21:	213		U.S.A.	
dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (San, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	
or Ite	E	1 Never Married 2 Marrie		No	Yes X No	Specify:	o i ilidani, oto.)	Specify: B1	
ours Day	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	'	2010	эреспу.		Specily: D 1	ack
21215-0036 Id within 72 hours af glene. or than "natural; or the Wedical Exam.	Completed	15. Decedent's (Specify only highest		(Give	ent's Usual Occup	during most of wor	king 1	6b. Kind of Business	s/Industry
Tage of the Car	du	Elementary/Secondary (0-12)	College (1-4or 5	5+)	OO NOT use retired	4)			
d 21215-0036 titled within 72 hours after Hygiene. wher then "neturel", or Ite ent, the Modical Examine	Ö		2years	N	urses	Aide			ospital
Ind 21215-0036  be tiled within 72 hours after death with the Marylan tal Hygiene.  of other than "natural", or Items 23a or 28a-1 show  event, the Modical Examiner must be notified at	Be	17. Father's Name (First, Middle, L	ast)				ne (First, Middle, M		
arylan should be ind Mental s marked o umatic eve	ဥ	Phillip Huds				Minnie		lifford	
ore, Maryland stand 2 should be tile thealth and Mental Hy item 27 is marked oth other traumatic event		19a. Informant's Name/Relationsh						City or Town, State,	
- c = ~ L			art/Husbar			nwood A			MD 21213
		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	3 □ Removal from State		natory`or other plac			0c. Location - City of	
imor Pages nent of I ant: If it		`4 □Donation 5 □Other (Sp		Druid R	idge Cer	m Feb.	10,2004	Pikesvi	lle, MD
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe once.		21. Signature of Funeral Service L	icensee	22	Name and Addres	ss of Facility	GS FIINE	RAL HOME	
<b>m</b> 88 <b>E 5</b> 8		Cally			412 E.	PRESTON	STREET	BALTO.	MD 21213
\$ 7 A		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused	the death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	RREAS		2 WITH	WINECD	TEAN M	ETHSTASES	Onset and Death
/Medical		resulting in death)	a. Due to (or as	a consequence of):	VIIII	MULSIN	W M	PI/13 1/13E3	101EARS
Examiner		2							
Marie Sale	je.	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a curisequence of):					
d ansit	Examiner	Cause (Disease or injury that initiated events							
60, 60 sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	dical		d. ==						
	edi		_						
. Box 6 death certitic e attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		-			23d. Date of de	livery
death	cia	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
that the de the by the a detached f	λys	9 □ Unknown	9□ Unknown						
I <b>Records, P.O</b> The law requires that the ste has been signed by the bage 2 should be detached.	by P	Part II. Other significant condition	s contributing to death b	ut not resulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
dS puires puires nd bi	d b	HYPERTENSI	VE CARD	LOVASCUL	AR DIS	SEASE	1 ☐ Yes	2 No 3 □ P	robably 4 Unknown
Vital Records, P sician: The law requires that certificate has been signed I rector, page 2 should be det	Completed	DIARETTES	MELLIT	116 11/6	ULIN DE	EDGNINGAL	7 24a. Was an	24h Were a	utopsy findings available
Rec ne lav s has ge 2 :	m	VIADOTES	711241			PENDEN	autopsy perform	prior to	completion of cause of
		CHRONIC	RENAL	INSUF	FICIEN		1 ☐ Yes 2	No 1 ☐ Yes	3 2 □ No
VISION Of VITAI Re Attending Physician: The I r death. ector: Alter this certificate he by the tuneral director, page	o Be	25. Was case referred to medical examiner?	Hospital:	~	3 DOA Othe	or:	th (Check only one		
- × × 5	H-	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie	/.\	JU DOA	4   Industria	ome 5 Resider 28d. Describe how	ce 6 Other (Spe	ecify)
Jing Jing Atter	io	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury	28c. Injury Work	k? Yes 2 □ No	200. Describe nov	injury occurred	
ISIO Mtendii death. ctor: A y the tu	ical	2 Accident investigation inves	ot be One Place of Ini	ury - At home, farm, stre		.03 2	28f Location /Str	et and Number or R	ural Paula Number
<u>-</u> = = -	Certification:	4 Homicide determin	building, et		ot, ractory, onice		City or Town,		arai rioale ivambei,
pital purs a		29a. Certifier (Certifying	Physicians To the heat	of my knowledge, death	annumed at the time	data and alasa		(-)	
Hos 24 hc Fun fely	lica	(Check only 2 Medical E	Physician: To the best xaminer: On the basis of and magner sta	t examination and/or inv	estigation, in my of	pinion, death occur	rred at the time, dat	e and place, and du	e to the cause(s)
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely tilled in by the funeral	Medical	29b. Signature and title of certifier	And mainer sta	and in Pl	29c. Liceos	e number	29	d. Date signed (Mon)	th. Day, Year)
F ≥ ₹ 8		- Amet	1	Dung M	yacaren)	N .	_	5/11:/	011
,		10000	van jivi	$\nu_{i}$		וטוע	10	777	V4
6		30. Name and address of person w	no completed cause of d	leath (Item 23a) (Type, I	2 1/ /	ALL CO	90 RING LA	NE BAI	TIMOKE
1		31. Date filed (Month, Day, Year)	A Region	ar's Signature	- KHIC	VLI) STA	VINCE LIT	VE N	W. 21210
Sta Registi			004	15 1	New York				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 4<sub>,</sub> Mary Catherine Ulrich February 2004 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium Health Center Anne Arundel Edgewater If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X1 F Yrs. **Director** 226-14-9689 84 29,1919 West Virginia Nov. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23e or 28a-f show 1 ☐ Yes 2 No Director Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 H Flanders Lane 20776 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examinar. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Cook School System Ith and Mental Hygie 27 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Lally unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace. Deborah L. Coleman/ Daughter 1502 H Flanders Lane, Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 XCremation 3 □ Removal from State Kalas Crematory Edgewater, MD `4 ☐ Donation 5 ☐ Other (Specify) 2-5-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner elce Sequentially list conditions, 1 by leading to in Tediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Enknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 1 ☐ Yes 2 No of Vital within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred **Division** 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 09 2004 Registrar

			For State Registrar	State of Man	yland / [	Departmen	t of Health ar e of Death	nd Mental H	ygiene Reg. No. 20	04 03580
	Physici	an	Decedent's Name (First, Middle, Last)	)				2. Date of I Month	Death Day	3. Time of Death
	/Medic		Sarah Elizabetl		ole			2		004 5147 PM
	Examin	er	4a. Facility Name (If not institution, give	1/		1 1	Town, or Location of	Death	4c. County	of Death
				1/5	SpilA		Sed4/e	Hre la Day	BAL	IMORE
	Funeral		10	IM 2XIF	d yrs. last bin	Yrs. Months	Days Hours	Min. (Month, I	Birth Day, Year)	Birthplace (State or Foreign Country)
	Director		163-24-4720 Usual Residence of Decedent		32			7/28/	1921	Pennsylvania
	yland		10a. State 10b. County	11	0c. City, Town	or Location				10d. Inside City Limits
	Mar	ţo	Maryland Baltimore	9	Esse	₹				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of W	hat Country?
	th wi		6 Mingo Lane			21	221		U.S.A.	
)	eme erre	Funerai		12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deced	ent of Hispanic Original orly Cuban, Mexican,	n? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race	- American Indian, , White, etc.
36	s afte , or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give		1 ☐ Yes			Specify:	, , , , , , , , , , , , , , , , , , , ,
8	should be filed within 72 hours after death with the Maryland not Mental Hygiene. I marked other than "natural", or Iteme 23e or 28e-1 show unatic event. The Medical Eventinar must be notified at	q p	3 Widowed 4 Divorced	Year or Dates:	100	Deceded to the	10			White
15	in 72 "na" r	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	10a.	Give kind of wo life. DO NOT us	k done durina most d	of working	16b. Kind of Bus	siness/industry
12	with iene. thac	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	CC	ook	,		Restaur	ran <del>t</del>
, <u>b</u>	Hyg other	Be C	17. Father's Name (First, Middle, Last)			XX.	18. Mother's	s Name (First, Midd	le, Maiden Surname	
<u>a</u>	lid be fenta rked ric ev	ToB	Jesse Lewis	Snyder			Jenni	e Mar	garet	Kalp
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23e or 28e-1 show other traumatic event. The Medical Evertifiest moust be confilled at		19a. Informant's Name/Relationship (Ty		19b.	Mailing Address	(Street and Number			_
	Health a tem 27 le		Ernest Trimble (S	Son)	6	Mingo L	ne Essex	. Marylar	nd 21221	
ore ?	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of cemeter	Disposition (Namy, crematory or o	ne of ther place)	Date	20c. Location - 0	City or Town, State
) <u>Ĕ</u>	nit. Pages artment of I ortent: If It injury or o		*4 □ Donation 5 □ Other (Specify)	lemoval nom State	Garder	ns of Fa	ith Cem.	2/5 2004	Baltimor	e, Maryland
Baltimore,	permit. Pages Department of Importent: If I eny injury or one		21. Signature of Funeral Service License	98			Address of Facility			
	40 E B B		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	Afran S	r	1407 0.	ld Eastern	Avenue	Essex, Ma	ryland 21221
760	/Medical Examiner and partial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	05/5 n: on:				Interval Between Onset and Death
Division of Vital Records, P.O. Box 68	The law requires that the death certifica ite has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of particles of the second of the sec	Fetal death	3 □Ectopic pr 5 □ Other (sp		-0.005 pg	23d. Date Mont	of delivery h Day Year
S,	gned gned	by P	Part II. Other significant conditions con			the underlying ca	use given in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
ord	w requir been si should	ted	Chronic Rena	FAILUK	10			10	Yes 2 No 3	Probably 4 Unknown
eČ	law r las be	Completed						24a. Wa	s an 24b. W	ere autopsy findings available or to completion of cause of
<u>=</u>	The page	Con						per 1∐ Yes	formed? de	ath? ☐Yes 2☐ No
/ita	sicien: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?					Death (Check only	one)	
of	nding Physicien: th. : After this certifics funeral director.	유	1 192 50140	lospital:		patient 3 DO		-	sidence 6 Other	
L C	ling F	on	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. T ear) In	ijury	Bc. Injury at Work?		how injury occurred	d
isi	vttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home far	M street feature	1 ☐ Yes 2 ☐ No		(Stroot and Number	or Rural Route Number.
Div	el or A s after il Dire	Certification:	4  Homicide determined	building, etc. (S	Specify)	m, street, ractory	onice		own, State)	or narar noote Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier Certifying Phys	sician: To the best of mer: On the basis of exand manner stated	amination and	death occurred a for investigation,	at the time, date and p in my opinion, death	place, and due to the occurred at the time	e cause(s) and man	ner as stated. d due to the cause(s)
	With Com	Σ	29b. Signature and title of certifier			29c	License number			(Month, Day, Year)
	6		1 4.0	~	m r	>	0239	462	2/2	104
	1		30. Name and address of person who co		h (Item 23a) (	Type, Print)		nit	1	
	Sta		DR. Jude Munes 31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Klins	QUARE DI	2. BAI/i	MORE M	d 21237
	Sta Registr		FFR 0 9 2004		a /	4 1	en down y			d 21237

DHMH 17 Rev 1/2001

TRIMble

SARAH

ORIGINAL

	_		1- For State of Ma	aryland / Depa		of He	eaith an	-		2110	ž.
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     Joseph I. Vitek     Ae. Facility Name (If not institution, give street and number)		4b. City, T	own, or l	_ocation of C	2. Date of Month	LARY	Year E = EVIC	34 12:23AM
	Funeral Director		214-03-2880 1ĂM 2□F	Center  (In yrs. last birthday)  85  Yrs.	If Under 1 Months	Year Days	If Under 24		of Birth Day, Year 2, 19	9. Bi	ttimore  outhplece (State or Foreign Sountry)  yland
	Ba-f show	ector	Usual Residence of Decedent  10a. State    10b. County   Queen Anne's	10c. City, Town or Lo Stevensvi	11e						10d. Inside City Limits
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, I'm Modical Exertine must be notified at once.	y Funeral Director	10e. Street and Number  100 Point Road  11. Marital Status  □ Never Married 2 ★ Married  12. Was Decedent F Armed Forces? 1 ★ Yes 2 □ N If Yes, Give	lo l	Vas Decede	nt of His y Cuban	panic Origin , Mexican, P Specify:	? (Specify Yes ouerto Rican, etc	USA	14. Race - Am Black, Wh	encan Indian,
21215-0036	fled within 72 hours lygiene. her than "natural" it, I'm Madical Ex	Completed by	3 Widowed 4 Divorced Year of Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5	(Give	dent's Usual kind of work DO NOT use acturi	done du retired)	ion iring most of Engine			Cind of Business	s/Industry
Maryland	2 should be fited and Mental Hygi is marked other sumatic event, II	To Be (	17. Father's Name (First, Middle, Last) I gnatius Joseph Vitek  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (	M	Marie	Name (First, Mi Kalus r Rural Route N	5		Zip Code)
Baltimore, M	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra <u>once</u> .		Joseph P. Vitek / son  20a. Method of Disposition  1  Burial 2  remation 3  Removal from State  4  Donation 5 Other (Specify)	301 0: 20b. Place of Dispo cemetery, cren Gardens o	natory or oth	of er place)		evensvi <sub>Date</sub> 9/04	20c. L	D 21666 ocation - City of	Town, State
Balt	permit. Depart Import any inj		21. Signature of Funey 1 ervise Licenses  23a. Part 1. Enter the disease, or complications hat caused shock, or heart failure. List only one cause on each tin	Ri the death. Do not ente		wson	Fune	ral Home	• T	050 Yor owson.	MD 21204 Approximate
68760,	Physician of Medical Physician and American and Standard	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes of the cause	ICULAR AR a consequence of): ARY ARTER a consequence of):			E.				Interval Between Onset and Death
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of the pregnant at th	2 ☐ Fetal death 3 ☐	Ectopic prec					23d. Date of de Month	livery Day Year
Records, P.	w requires that been signed to should be det		Part II. Other significant conditions contributing to death bu	t not resulting in the un	nderlying cau	se given	in Part I.	1	☐ Yes 2	<b>X</b> No 3 □ P	o the cause of death? robably 4 Unknown
	ysician: The lav is certificate has director, page 2	Be Completed	HYPOTHYROIDISM  25. Was case referred to medical examiner?			2	26. Place of	_ a		death?	utopsy findings available completion of cause of 2/KTNo
Division of Vital	ding Ph h. After th funeral	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending (Month, Day) 20 Accident investigation 3 Straids 6 Could not be	Yeer) 28b. Time of Injury	280 M		4 🗀 Nursin	28f. Locatio	be how injui	ry occurred  and Number or R.	ural Route Number,
ā	Hospitel 4 hours : Funerel ely filled	edical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of and manner stall a	f my knowledge, death	occurred at restigation, in	the time, my opin	date and pl	ace, and due to	Town, State the cause(s) ne, date and	and manner as	s stated. b to the cause(s)
	To the I	M	29b. Signature and title of certifier  30. Name and address of person who completed cause of de	ath (Item 23a) (Type I		icense n	number		29d. Da	te signed (Mont	h, Dey, Year)
2 202	Sta Registr		BOON F. LIM M.D. 7601	OSLER DR		OWS	ON M	ARYLANI	212	<u>0</u> 4	

			1 - State Registrar	State of Ma	ryland /	Department of Certificate	of Health and of Death	•	giene Reg. No.	2004	03582
	Physic	ian	Decedent's Name (First, Middle, Last					2. Date of De.		Yeer	3. Time of Death
	/Medi Examir	cal	Melvin James Wha. Facility Name (If not institution, give	nite Sr street and number) HOSPITAL	Corder	4b. City, To	wn, or Location of Dea	th	B	2004 County of Death	re
2	Funeral Director		5. Šocial Security Number 6. Se 220 30 4660  Usual Residence of Decedent	x 7. Age X 69	(In yrs. last bi	Yrs. If Under 1 \ Months D	Year If Under 24 Hrs Pays Hours Min	. (Month, Da		Cour	lace (State or Foreign htry) nnsylvania
	the Maryland 28a-f show nutflied at	tor	10a. State 10b. County  Maryland Baltimore		10c. City, Tov	vn or Location				1	0d. Inside City Limits  1  Yes 2 No
	with the M e or 28a-f	Direc	10e. Street and Number 408 Old Home Road			10f. Zip Co				en of What Cour	ntry?
036	within 72 hours after death with the Maryland ene. Than "natural", or llams 23e or 28e-f show the Medical Expiration count by multipled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1	)	13. Was Deceden	t of Hispanic Origin? ( Cuban, Mexican, Puer	Specify Yes or No nto Rican, etc.)		4. Race - Americ Black, White, Specify:	etc.
Nhute, Melvin Baltimore, Maryland 21215-0036	within 72 ho iene. 'than "natur ine Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	-)	life. DO NOT use I	fone during most of wo etired)	orking		od of Business/Ind Dry Racing	
$M[c]_{V[D]}$	s 1 and 2 should be filed within thealth and Mental Hygiene. If Health and Mental Hygiene. It is marked other than other traumatic event, its M	To Be C	17. Father's Name (First, Middle, Last) Samuel Ellsworth White	-,		chine Operat	18. Mother's Na	me (First, Middle, rie Mauer	Maiden :		Tiace W.
Mary Mary	1 and 2 should be Health and Men's tam 27 is market other traumatic		19a. Informant's Name/Relationship (T	ype, Print)		ar tribat 15	treet and Number or R				
Whate, Baltimore, I	permit. Pages 1 ar Department of Hea Important: If itam any injury or otha		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,		cemete	ery, crematory or other wn Cemetery	February 9 20			eation - City or To	
≪	permit. Departr Imports any inje		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Chan-i	Ci	Lassahn Fu	odress of Facility Ineral Home In Ineral Baltin	nc more.Marvl:	and 21	236	
0	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Empy	Đ.		f dying, such as cardia	ic or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. Bronch O  Due to (or as a	pleur	ral fishu	la				2 months
8760,	cate be executed obysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a			ng				2 months
Division of Vital Records, P.O. Box 68	as as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal deat	h 3 Dectopic pregr 5 Dother (speci			2	3d. Date of delive Month	ory Day Year
rds, P	w requires that the been signed by the should be detach	ed by Pt	Peripheral Vasc	intributing to death but	not resulting	in the underlying caus	se given in Part I.	23e. Did to	/		ne cause of death?
al Reco	: The law requ cate has been ; page 2 should	Completed by	COPD					24a. Was autor perio 1 □ Yes		24b. Were auto prior to con death? 1 \( \text{Yes}	psy findings available npletion of cause of 2 No
f Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatien	t 2 ER/O	utpatient 3 DOA	Other	eath <i>(Check only c</i> Home 5 Resid		Other (Specify	/)
o noi	nding Ph th. : After th e funeral	ation:	27. Mannef of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of 28c. Injury M	Injury at Work? 1 Yes 2 No	28d. Describe I	how injury	occurred	
Divis	tal or Attendi s after death. al Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, f (Specify)	arm, street, factory, o	ffice	28f. Location (S City or Tox		l Number or Rura	l Route Number,
×	To the Hospital or within 24 hours after To tha Funaral Director Completely filled in the comple	edicai			examination a		he time, date and plac my opinion, death occ				
	To the within 2 To tha	X	29b. Signature and title of certifier	en n	U.D.	Ī	00595	26	21	signed (Month,	1
_	1,5		30. Name and address of person who of AUDREY LIU 9	000 Frant	VIII C	(Type, Print)	ive Bal	hmore,	Md.	212.	37
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	marke					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. & 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev Year **Physician** 2004 Herbert Oliver Wilder TODRUAR /Medical 4e Fecility Neme, (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner (WKVERS De ARFORA LORIEN If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Hours 1**∑** M 2□ F Months 705-09-8296 Director 92 02/13/1911 Maryland Usuel Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location must be notified at 1 ☐ Yes 21 No Director MD Harford Forest Hill 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1909 Treeline Drive Funeral 21050 U.S.A. 14. Race 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married ð 1 ☐ Yes 2 🎇 No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced Year or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within than Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. 12 Supervisor B & O Railroad other 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nant of Health and Mental Herbert Herman Wilder Olive A. Brown 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Herbert C. Wilder (son) 2408 Gilwood Drive - Joppa, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Department of Important: If It eny Injury or o 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Highview Memorial Gdns. 02/05/04 Fallston, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, MD 21087 aas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? paga 2 should be datached 1 □ Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? ZIZINO 1 ☐ Yes 2 ☐ No t Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ★☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 INo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth 5 Pending investigation 1 Naturet 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  $\theta$ 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 6 an llul 32 Registrer's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

FEB 0 9 2004

Baltimore,

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 🤈 AMEND ITEM #5 PER FH G828 2/24/04 Gartificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Frank Raymond Woelfer 4:42 A M February 4,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 400 Stefan Court Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 200 3 Security Number 212-30-0963 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1**⁄2**M 2□ F 70 Yre Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show rthen "natural", or Itams 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Dundalk Maryland Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21222 United States 400 Stefan Court filed within 72 hours after death Funerai 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2€3tNo If Yes, Give Year or Dates: 1 Never Married \*\* Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 10 Years Baker other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental It 27 is marked of traumatic ever Pages 1 and 2 should be Ruby Clapp Frank Woelfer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is eny injury or other trau Dundalk, Maryland 400 Stefan Court Mrs. Ann L. Woelfer / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park 2/7/2004 Dorsey, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu / g Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DRAL CANCE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitet or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Box 68760, Completed by Physician/Medical ding IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown þ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 robably 4 Unknown s need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Director: After the 28b. Time of 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ILWABENA Campbell Bird, OSEI- BOATENG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month, Physician 6, 2004 -AWRENCE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NURSING HOME PARKUILLE BALTIMIZE PAKCresT IllAGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 213-09-9240 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PARKULE MD 13ACTIMORE Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21234 U.S.A Walther BULD 8832 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WhiTe δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12+1 Photographer MD Tech 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, þe Mental LAWrence Wenchel, ANNA Meidling Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Newsek DURSO DR De 19711 13 YASSER 100 JEAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 19/04 4 Donation 5 Other (Specify) cemetery PARKWOOD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERAL ( HO ME CHID. -STella HARTIEY Willes illa RD. BA16. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dise to or condition reting in death) Arterioschotic vascular Physician /Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 200 9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fibrilation 1 Yes 2 No 3 Probably 4 Minknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No tallure Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of D th 1 Abatural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a
To the Funeral I
completely filled 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 100 25642 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud/Balto MD Kendall R Faulknerma/8800 Walthon

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2004

32. Registrar's Signature

DAP State of Maryland / Department of Health and Mental Hygiene State Registrar Unpend Item#23a,27,28a-f,Per ME,G825e2t/filo/10teg/f Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Wooden FEBRUARY 4,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner SINAI HOSPITAL BALTIMORE CITY Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** iX M 2□F 213-62-566. Usuat Residence of Decedent 5662 Director the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exeminer must be notified at Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? with 1191 21 20 items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: ac 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12/5 Ssembly 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Wooden 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belvedere Bernadotte 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 5 permit. Page Department of Important: If any injury or Gard! 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DDC8 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Complications of Remote Gunshot Wound To The Abdomen 3405 W. F Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, to along to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ŏ Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗆 Yes 2 🗆 No 3 ☐ Probably 4 🔼 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 2 No 12 Yes or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1√2 Yes 2 □ No y patient 2 ER/Outpatient 3 DOA this I Director: After the 28a. Date of Injury (Month, Day Year) 2/13/98 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 10:22 subject was shot death. 1 ☐ Yes 2 X No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TOadway 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Etting and Baker St., Baltimore, MD within 24 hours a To the Funeral C To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Application of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50 74501 ,2004 **OCME** FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1810 31. Date filed (Month, Day, 111 Penn Street, Baltimore, Maryland 21201 Register's Signature State

Registrar

14			For State Registrar	of Maryland / Depa	rtment of He tificate of De		, ,	ene g. No. 200	03587
			Hegistrar  1. Decedent's Name (First, Middle, Last)		imouto or B	Julii	2. Date of Death		3. Time of Death
	Physicia	an		Wilson			Month	Day Year	м
	/Medic		Elijah  4e. Fecility Name (If not institution, give street and		4b. City, Town, or Lo	ocation of Death	FEBRUAR'	Y 3, 2004 4c. County of Dea	4:32 P.
	Examin	er	JOHNS HOPKINS BAYVIEW M		BALTIMOR			n/a	
	E	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   I	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Funeral Director		245-56-2695 1CM 2CF	65 Yrs.	Months Days	Hours Min.	Oct.7,	1938 Nor	thCarolina
ight.	v		Usual Residence of Decedent						
	how		10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	e Ma	ctol	MD n/a	Baltimo	ore				1X Yes 2 No
	or 28	Oire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
	23a	rai	2019 E. Belvedere	Ave.		239		U.S.A.	
	r des	nue	Armed		Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or It	by Funeral Director	If Yes.	s 2∑No Give 1	☐Yes 2☐XNo	Specify:		Specify:B1	ack
Ö	within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28e-f show the Modical Exemplest must be notified at	q pe	15. Decedent's Education	r Dates:	ent's Usual Occupation	00		16b. Kind of Business	Andustry
쟌	"naf	Completed	(Specify only highest grade complete	(Give i	kind of work done dur OO NOT use retired)	ring most of worki	ing	Ob. Kind of Business	unidastry
12	withi ene. then	mc d	Elementary/Secondary (0-12) College	e(1-4or5+) Machir	ne Opera	ator		Cambrida	e Iron Co.
2	filled Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)	Machili			(First, Middle, M		e iron co.
Baltimore, Maryland 21215-0036	d ta b	To Be	Unknown			Ne	llie	Wils	on
ary	should and Men amarke umatic	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and	d Number or Rura	al Route Number,	City or Town, State,	Zip Code)
ž	of Health are item 27 is		Joann Wilson/wife	2019	E. Belve	edere A	ve. Ba	lto. MD	21239
<u>6</u>	item of He othe		20a. Method of Disposition	20b. Place of Dispos				Oc. Location - City o	Town, State
E	Page nent c nt: If rry or		1 □ Burial 2 □ Cremation 3 □ Removal from 1 □ Chemistry Specify)	om State	of Faith	CemFeb	.9,2004	Baltin	nore,MD
alti	permit. Pages 1 and Department of Heall Importent: If item 2 eny injury or other once.		21. Signature of Funeral Service Licensee	22	Name and Address	of Eacility			
Ö	9 6 E 8 8	V 9	(della	12	112 E. PF	RESTON	STREET	BALTO.	MD 21213
ā,			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not entern each line.	er the mode of dying,	such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause /Final	EROSCIEROTIC	MAR DICKT	ARILIAN	DISE	ASIE	Onset and Death
В	/Medical			to (or as a consequence of):		-3000/17			
	Examiner		Sequentially list conditions, b						
	p .≅	ner	frany, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (ur as a consequence of).					
	acute ind trans	Examiner	that initiated events c.						
Ő,	e exe	ĒX	resulting in death) Last Due	to (or as a consequence of):					
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical	d						
9	eath certific attending p	/Me	IF FEMALE:	outcome of pregnancy					
Вох	ath c	by Physician/Me	up the past 12 months?		Ectopic pregnancy			23d. Date of de Month	Day Year
o.	the a	/sic	1 Ves 2 No	egnant at time of death 5 🗌 iknown	Other (specify)				
٥.	that the ded by the detached	P	Part II. Dther significant conditions contributing to	death but not resulting in the un	deriving cause given	in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Records,	Se G	l by		•	, , , , , , , , , , , , , , , , , , , ,		1 🔀 Ye	s 2 □ No 3 □ P	robably 4 Unknown
O	w requir been si should	etec					Ode Mho es	24h Wasa a	utanov findinas available
3ec	has l	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
							1⊠ Yes 2	□ No 1 □ Ye	2 □ No
Vital	certif recto	Be	25. Was case referred to medical examiner?  Hospital:		Other		(Check only one		
o	Physicien: r this certific ral director,	: To	M Tes 2 No	☐ Inpatient 2  ER/Outpatient  ite of Injury 28b. Time of	28c. Injury at		me 5∐ Residei 28d. Describe ho	nce 6 Other (Spe w injury occurred	ncify)
	ding h. After fune	tlon	1 ☑Natural 5 ☐ Pending (M	fonth, Day Year) Injury	Work?	s 2 🗆 No		,,	
S	Attending r death. ector: After by the fune	lica	3 Suicide 6 Could not be 380 Pi	ace of Injury - At home, farm, stre			28f. Location (Str.	eet and Number or R	ural Route Number,
Division	after Direction by	Certification:	4 Homicide determined bu	ilding, etc. (Specify)	,,		City or Town,	State)	
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.			the best of my knowledge, death					
	the Ho hin 24 I the Fu	edical	(Check only one) Medical Examiner: On the	e basis of examination and/or invitanmen stated.	estigation, in my opin	ion, death occurr	ed at the time, da	te and place, and du	o to the cause(s)
	To the To the Comp	Z	29b. Signature and title of certifier		29c. License n	umber	29	d. Date signed (Mon	th, Day, Year)
)			> Unell_		0.C.	M.E.	F	EBRUARY 4,	2004
	X		30. Name and address of person who completed c			thencat T	7a1+	. V.	.a. 21201
	U		ANA RUBIC	/	111 Penn S	creet, l	PATERIMOLO	e, marylar	KT STSOT
,	Sta Registr			2. Begistrar's Signature	and t				

			1 lease	State of Maryla			t of Health ar	•		_	
			1 - For State Registrar	Olato of Maryla	-		e of Death	,	Reg. No.	2001.	03588
			Decedent's Name (First, Middle, La	st)				2. Date of De	eath		3. Time of Death
	Physici /Medic		Sadie Reb	ecca Yoak				Month	Day		10:50 AM
	Examin		4a. Fecility Name (If not institution, giv	2 3 4	1 1	4b. City,	Town, or Location of I	Death		County of Deeth	
			00.01	eart Hosp			mberl			Allega	ny
	Funeral	-500	5. Social Security Number 6. S	- W-	s. last birthday Yrs.	/) If Under Months		Min. (Month, D.			olece (State or Foreign ntry)
9.	Director		232-26-3357 Usuel Residence of Decedent	99	115.			April	17,19	904   Wes	t Virginia
	land		10a. State 10b. County	10c. 0	City, Town or L	ocation					10d. Inside City Limita
	Man Man	to	WV Miner	a1	Keys	ser					1∭ Yes 2 No
	or 28	lrec	10e. Street and Number			10f. Zip	Code		10g. Citi	izen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f ehow	Funeral Director	47 "D" Street				26726			USA	
	ar dez	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Deced If Yes, spec	ent of Hispanic Original Original Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	0-	<ol> <li>Rece - Ameri Black, White,</li> </ol>	
50	hours after tural', or its	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify: T.T	nite
2-003p	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f ehow calcal Examinar must be molified at	ed	15. Decedent's E	ducation	16a. Dec	edent's Usua	I Occupation		16b. Ki	ind of Business/Ir	
2 2	within 72 ene. than "nei te Medic	ple	(Specify only highest grant Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	- (Giv life.	e kind of wor DO NOT us	k done during most o e retired)	f working			
Z	be filed within tal Hygiene. d other than event, tre M	Completed	4		Но	memak	er			Own Ho	me
	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Last	)			18. Mother's	s Name (First, Middle	, Maiden	Sumame)	
<u>X</u>		၉	George Swick					llie Borr			
=	01 00 - 00		19a. Informant's Name/Relationship (				(Street and Number		er, City o	r Town, State, Zij	Code)
a)	s 1 and f Health item 27 other to		Sharon Winkler/ 20a. Method of Disposition		Place of Disc	osition (Nam	ne of	ser, WV	26726 20c. Lo	ocation - City or To	own, State
ē E	8°= 5		1 Burial 2 Cremation 3 C  4 Donation 5 Other (Special		cemetery, cre			Feb. 5	77		
altimor	nit. Pa vartmen ortant: injury is.		21. Signature of Funeral Service Lice				al Gardens d Address of Facility	2004 Smith Fu		yser, W	V
ñ	De de la company		Brian 7	Sult	5 8	35 S. 1	Main Stree				6
à	* *		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not er	nter the mode	e of dying, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between
, Š.	Physician		Immediate Cause (Final disease or condition	SEPS	7 <	SUN,	J.Rome			/	Macy I Week
	/Medical		resulting in death)	Due to (or as a conse	equence of):	2//-				/	7.70.7
	Examiner	_	Sequentially list conditions,	b. Bilderal	Ph	eum or	ne				four   week
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
_6	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):						
		calE	· ·	ď							
200	certificate rding phys										
X Q Q	th cer endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		□Ectopic pre	egnancy		1	23d. Date of deliv	*
	e death he atten sed for u	sicia	in the past 12 months? 1 ☐ Yes 2 № No	4☐Pregnant at time of 9☐ Unknown		Other (sp				Month	Day Year
т Э	requires that the reen signed by th hould be detache	Completed by Physician/Med	9 Unknown  Part II. Other significant conditions	contributing to death but got r	aculting in the	underhinger	ause awen in Part I	23e Did	tobacco u	use contribute to t	he cause of death?
Ś	w requires that been signed to should be deta	by		DENTA	_	dildenying ca	1036 given in Fait i.		Yes 2[		4 .
Kecords		etec	01-03/2/3/3	DE 47 AT	17/16:0			24a. Was			
ĕ	sician: The law certificate has b irector, page 2 s	dm						auto	psy ormed?	prior to co death?	ppsy findings available impletion of cause of
_	n: Th	e Co	25. Was case referred to medical	I			OC Flore	1 ☐ Yes	2 No	1 🗆 Yes	2 No
>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpatient 2	☐ ER/Outpatie	ent 3 DO	Other	ing Home 5 Res		6 ∏Other /Specia	(v)
O	g Phy ler thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 2	Bc. Injury at Work?	28d. Describe			,,
<u>o</u>	andin ath. or: Att	atlo	Natural 5 Pending investigation	n	IIIquiy	М	1 ☐ Yes 2 ☐ No				
DIVISION	r Attracted inected	Certification:	3 Suicide 6 Could not be determined			treet, factory	, office	28f. Location ( City or To		d Number or Run )	al Route Number,
<b>a</b>	oital o		- V								
	Hosp 24 ho Fune Fune	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	ith occurred a nvestigation,	at the time, date and p in my opinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as s I place, and due t	tated. the cause(s)
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Mec	29b. Signature and title of certifier	and married stated.		29c	. License number		29d. Dat	e signed (Month,	Day, Year)
	- s - ō		91	sechin pour		D	26907		FERR	wary 2	2004
	8		30. Name and address of person who		em 23a) (Type		-10(		1 -31	7	
			HARTIT SIDHU			SH R	DAD CL	MBERLA	VD, n	nD. 21	302
*	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	book!			,		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 17, 2004 **Physician** ETHEL MAE WARD PIGMAN ARNOLD 12:15P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Anchorage Nursing & Rehabilitation Wicomico 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 ■ M 2 F Maryland 213-24-4589 73 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Modical Examiner must be notified at 1 Yes 2 No Director Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 USA 2353 Klej Grange Road filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Bookkeeper Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 9008. Be Edna Francis White Robert Lee Ward, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 New Bridge Road, Pocomoke City, MD 21851 Leona Hill/ Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal Irom State
4 Donation 5 Other (Specify) 1/23/04 Salisbury Crematory Salisbury, MD 21804 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Dean 103 Linden Ave., Pocomoke City, MD 21851 m001129 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 USMIL 24 Aun /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence ol) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transil the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel D 160 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/19/04 Natur 047054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 NATEGAN 1415 SALISB Wy 5. DIVISIUM 5 beel Vel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

			For State Registrar	State of Marylar		artment of tificate of		ental Hygien	711111.	03590
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  David  L	Au	davi			2. Date of Death Month January	7 4 2804	3. Time of Death 10:02am
	Examir	100	4a. Fecility Name (If not institution, give s Howard Count	of General	hosp.	C	or Location of Death	r	lc. County of Dealh	and.
4	Funeral Director		5. Social Security Number 126 18 9221  Usual Residence of Decedent	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Yea Months Days	s Hours Min.	8. Date of Birth (Month, Day, Yea March 23,	ir) Cou	place (State or Foreign intry) Hampshire
	er death with the Maryland Items 23a or 28a-f show Let mast to colling at	tor	10a. State 10b. County  MD Howard		ity, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		<u> </u>	10f. Zip Code		10g. (	Citizen of What Cou	intry?
	23a c	aiD	6500 Freetown Road	1		2104			United St	
920	등 등 등	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1942		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🔀 No	Hispanic Origin? (Spe ban, Mexican, Puerto o <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	도 교육	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of worki	ng 16b.	Kind of Business/li	ndustry
212	filed within Hygiene. ther then int, the Me.	mo.	12	College (1-401 34)	CEO			A-	ir Exchan	ge
nd		Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maide	en Sumame)	
yla		2	Dorilla Auclair	an (Grind)	10h Maille	- Address (Cter	Elsie Ca		vor Tourn State 7	in Code)
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Typ				Fox Court			
	s 1 and 3 Heelth item 27 other tr		Nancy Auclair/Dauc  20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pi			Location - City or T	
OE.	Pages nent of nnt: If it iry or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)			ematory		<b>-</b> 2004 Ca	atonsvill	e, MD
Baltimore,	permit. Page Department of importent: If any injury or gnce.		21. Signature of Funeral Service License	M010			ress of Facility Har Columbia P			ily FH Inc. MD 21043
\$4. S. S.	Physician /Medical Examiner	e.	23a. Part. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	quence of):	er the mode of di the d perter	ying, such as cardiac of Shocke	r respiratory arrest,		Approximate Interval Between Onset and Death
68760,	dea h certificate be executed e attending physician and id for use as the burial-transit	edical Examine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		CF L	Deálelts	7	1	
O. Box	that the dea'h certifical ied by the attending phy detached fo' use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3□	Ectopic pregnan Other (specify)	icy		23d. Date of deliv	very Day Year
ords, P.	The law requires that the ste has been signed by tho bage 2 should be detached.	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause o	given in Part I.		o use contribute to	the cause of death?
Record		Completed						24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to c	opsy findings available ompletion of cause of 2 No
/ita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Death			
of Vital	문 두 등	. To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	28b. Time o	IL SU DOA	4 🗆 Nursing Ho	me 5 Residence 28d. Describe how in		ify)
Division	To the Hospitel or Attending Phymitin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - At I building, etc. (Spec	Injury	M 1	□Yes 2□No	28f. Location (Street City or Town, St.	and Number or Ru	ral Route Number,
ā	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:		29a. Certifier Certifying Phys	sician: To the best of my kn	nowledge, deat	h occurred at the	time, date and place,	and due to the cause	(s) and manner as	stated.
	ths H in 24 the F nplete	Medical	one)	and manner stated.		20-1		204 /	Data sissed (Manth	Day Year
)	To with	4	29b. Signature and title of certifier	- My	-	29C. Lice	050870	Fa	Date signed (Month	21029
	02		30. Name and address of person who co	5005 219		Bell	lane (	larliser	ille MI	21029
4	Sta	ate	31. Date filed (Month, Day, Year)	32 Yegistrar's Sign	hature A	and a				

			1 - State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of Fertificate of			ene g. No. 2004	03591
	Physici		Decedent's Name (First, Middle, Last)  Kevin	Daun	Armour			2. Date of Death Month		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dear		4c. County of Death	11.55A
	Funeral Director		11604 Rope Knot R 5. Social Security Number 6. Sex 235 78 9881		je (In yrs. last birthda 54 Yrs.	Lusb y) If Under 1 Year Months Days	Y If Under 24 Hrs Hours Min		Calvert Year) 9. Birthi Coul 1949 We	place (State or Foreign ntry) st Virgin
	ъ		Usual Residence of Decedent  10a. State 10b. County  Maryland Calvert		10c. City, Town or Lusby	Location		pope 13		1 ☐ Yes 2 ☒ No
	h with the 3s or 28s	al Director	10e. Street and Number 11604 Rope Knot	Road	J	10f. Zip Code 20657	7	10 U	g. Citizen of What Cou Inited St	ntry? ates
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23s or 28s-1 show any injury or other traumatic event, the Medical Examinate rust be natified at ODGs.	by Funerai	11. Marital Status  1 Never Married 24 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑Yes 2 ☐ If Yes, Give Year or Dates	No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0036	within 72 ho iene. rthan *natur ithe Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Giv life.	edent's Usual Occup re kind of work done o DO NOT use retired CVICE Mail	during most of wo d)	rking	sb. Kind of Business/In	
Maryland 2	uld be filed Mental Hyg Irked other	To Be C	17. Father's Name (First, Middle, Last)  John William A	rmour				me (First, Middle, Ma cille Rac		
	1 and 2 sho Health and 1 em 27 Is me thar traums		19a. Informant's Name/Relationship (Ty) Cindy Armour - W  20a. Method of Disposition	*	1160	4 Rope F	Knot Rd	. Lusby	City or Town, State, Zip MD 2065	7
Baltimore,	nit. Pages artment of P ortant: If it injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			ematory or other place Litan Fig. 22. Name and Address	ss of Facility			own, State ia Virgini
eg E	permi Depar Impo any ir	9 9	23a. Part 1. Enter the disease, or compli	cations that caused	the death. Do not e	405 Brooms	R s Is. m.	Port Republ		Approximate
i	Pnysician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		Pulmo a consequence of):	ngry	Fie	brosis		Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of): a consequence of):					
.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive	ory Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did toba 1 □ Yes	cco use contribute to the	ne cause of death? ably 4 □Unknown
al Record		Completed						24a. Was an autopsy performe	prior to co	psy findings available impletion of cause of
Division of Vital	Attanding Physician: Thir death. ector: After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		of 28c. Injury Work	er: 4 ☐ Nursing H	ath (Check only one) Home 5 Aesiden 28d. Describe how	ce 6 Other (Specifi	()
Divisi	tal or Attanors after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directonpletely filled in by	edical	(Check only 2   Medical Examin	ician: To the best er: On the basis of and manner sta	f examination and/or i	nvestigation, in my of	pinion, death occu	urred at the time, date	se(s) and manner as si e and place, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier	Kalo	a m	29c. License	00 52	1147	Jan. 9, 200	
1	2+1		30. Name and address of person who	Sorth	1 111	Print Pr	ince	Frederic	1cm	20476
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	Signature	Coule				

			State of Maryland / Dep	eartment of Health and M			
		1 - For State Registrar		ertificate of Death	Reg. N	- 7 H H I I I	03592
Physic	ion	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year	3. Time of Death
/Med		Thomas A. Brook			January 23	, 2004	4:33 P <sup>™</sup>
Exam	ner	4a. Fecility Name (If not institution, give s 2172 Bonnie Lan		4b. City, Town, or Location of Death Waldorf		c. County of Death Charles	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Yea		place (State or Foreign
Director		021-10-5395	M 2□F 89 Yrs.	Months Days Hours Mill.	lug. 11, 1	914 Engi	änd
/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		1	Od. Inside City Limits
e Man a-fah	ctor	MD Charles	Waldorf				1 ☐ Yes 🎾 No
with the	Director	10e. Street and Number		10f. Zip Code		itizen of What Cour	•
leath v	Funeral	2172 Bonnie Lane	Was Decedent Ever in U.S. 13.	20601 Was Decedent of Hispanic Origin? (Spe		ited Stat	
If yiellid Z I Z I D-UUSO should be filed within 72 hours after death with the Maryland ad Mental Hygiene. marked other than "natural", or Items 23e or 28e-f ahow matic event, it a Medical Eventh or mast be notified at	Fun	1 □ Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
ural',	d by	3 Widowed 4 Divorced	Year or Date 1936-1945	1 ☐ Yes 2 X No Specify:		Specify: whi	
in 72 in 72 in Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b.	Kind of Business/In	dustry
d with giane.	E	Elementary/Secondary (0-12)	College (1-4or 5+) Manag			m and Hor	ne Supply
Maryland ZIZI3-UU30 Id 2 should be filed within 72 hours af Ith and Mental Hygiene. 77 is marked other than "natural", or traumatic event, tra Musical Extra	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Maide	,	
should be and Mental a marked o	2	George Brooks  19a. Informant's Name/Relationship (Type	an Print) 10h Mail		Woodhouse		0.44
MC2		Evelyn Doris Broo		ing Address (Street and Number or Rura Bonnie Lane, Wald			(Code)
DallIMORE,  bermit. Pages 1 ar  Department of Hea  Important: If item  any injury or othe  ange.		20a. Method of Disposition	20b. Place of Disp			Location - City or To	own, State
parillinor permit. Pages Department of a Important: If it, any injury or o once.	١.,	1 🏻 Burial 2 □ Cremation 3 □ Re  1 4 □ Donation 5 □ Other (Specify)	St. Peter	r's Cemetery 01-27	-2004 Wal	dorf, Mar	yland
Dall Separt Mport Iny inj		21. Signature of Funeral Service License		22. Name and Address of Facility HU			
- 45240		23a. Part1. Enter the disease, or complic	ations that caused the death. Do not er	.0.B0X 156, WALDOR		D 20604	Approximate
Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.  LUNG CF		,,		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	TN CE /			3 MONTHS
Examiner		Sequentially list conditions, b.					
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).				
rou, te be executed ysicien and e burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
- e × e	ical	d					
The COLOS, F.O. BOX 00/07. The law requires that the death certificate but has been signed by the attending physic page 2 should be detached for use as the b	by Physician/Med	IF FEMALE:	c. If yes, outcome of pregnancy				
box leath cert attendin	cian	in the past 12 months?	1 Live birth 2 Fetal death 3 (	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
at the d	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	7/			
ires that the de signed by the a		Part II. Other significant conditions con-	tributing to death but not resulting in the t	underlying cause given in Part I.		use contribute to th	
w require been signatured	eted				1 ☐ Yes 2		ably 4 Dunknown
The law requires tate has been signe page 2 should be o	Completed				24a. Was an autopsy performed?	24b. Were auto- prior to cor death?	psy findings available apletion of cause of
	0	25. Was case referred to medical		26. Place of Death	1 ☐ Yes 2 ☑ N	o 1 ☐ Yes	2□ No
Physici Physici r this cer ral direc	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 ER/Outpatie	Othor	ne 5 Pinesidence	6 ☐Other (Specify	()
ding P. After t	inol.:	27. Manner of Death 1 2Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how inju	ury occurred	
the the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	8f. Location (Street a	nd Number or Rura	l Route Number
s after	Certification;	4 Homicide determined	building, etc. (Specify)	,	City or Town, Stat	(e)	
Hospit 4 hour Funera		(Check only 2 Medical Examin	ician: To the best of my knowledge, dealer: On the basis of examination and/or in	th occurred at the time, date and place, a	and due to the cause(s	s) and manner as st	ated.
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month, I	
7 <u>₹</u> 8		) Lege	~ ~ ~ ~	728281			•
		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type,	Print\			6,2004
DB 10=1		NELSON BENDE	RS M.D., 9131 PI	SCATAWAY ROS	D, CLIN	LON WI	> 20 735
St Regist	ate	31. Date filed (Month, Day, Year)	32. Egistrar's Signature	hack a			

			1 - For State Registrar Amend Item#2	State of Man 28a-fperMEOG828				nd Mental Hy	giene Reg. No.	2004	03593
	Physici		Decedent's Name (First, Middle,					2. Date of D Month January	Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, 5271 Pulaski	give street and number)		4b. City, Town, or Per	Location of I	Death		ounty of Death	
Ī	Funeral Director		221-42-4315	5. Sex 7. Age (II 1 1 1	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	rth ay, Year) 15,195	9. Birthr Coul 5 De	place (State or Foreign ntry) elaware
9500-6	be filed within 72 hours after death with the Maryland atal Hygiene.  do ther then "netural," or liems 23a or 28a-f show or other then "netural," or liems 23a or 28a-f show event, the Meutral Exumana included at	ed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Delaware New C  10e. Street and Number  2117 Faulkland  11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Road  12. Was Decedent Eve Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:	16a Dece	Wilmingt  10f. Zip Code  19  Was Decedent of Hill If Yes, specify Cuba  1 Yes 2 No	805 spanic Origin n, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	0- 14.	U.S.A Race-Americ Black, White,	ean Indian, etc. White
C1212	e filed within 72 al Hygiene. I other then "ne vent, the Wedic	Completed	(Specify only highest Elementary/Secondary (0-12) Twelve Years	grade completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired Salesman	furing most o		Auto	mobile	Industry
yland	should be file and Mental Hy, marked othe umatic event,	To Be (	17. Father's Name (First, Middle, L Roy	ast) Billips					Bowman		
a	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationsh Tandra Crescenz  20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 4 □ Donation 5 □ Other (Sp  21. Signature of Funeral Service L	Z i  3 💆 Removal from State ecify)	2117  20b. Place of Disportentery, cre  Hockessi	Faulkland position (Name of matory or other place in Cremato 2. Name and Address ee A. Pat	Road ory 0	or Rural Route Nurm, Wilming Date 1/21/04 & Son Fu land 219	20c. Loca Hocke	elaware tion-City or To ssin, E	e 19805 own, State Delaware
,/60,	ate be executed hysician and hysician and Examiner into burial-transit	licai Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	1	insequence of):	ter the mode or dyin	y, suuri as ua	arulac of Tespiratory	arrest,		Approximate Interval Between Onset and Death
O. Box 68	the death certifical the attending phoched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ∐Live birth 2 [ 4 ∐Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			230	d. Date of deliving Month	ery Day Year
7	The law requires that the de- ste has been signed by the a bage 2 should be detached f	þ	Part II. Other significant condition	ns contributing to death but r	not resulting in the c	underlying cause give	en in Part I.		tobacco use ]Yes 2□I		he cause of death? Dably 4 A Únknown
al Records,		Completed						24a. Wa aut per 1 🗆 Yes	s an 2 opsy formed? 2/2 No	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
of Vita	Physician r this certifi ral director	To Be	25. Was case referred to medical examiner?  1/2 Yes 2 □ No  27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpatie		er: 4 🗆 Nurs	of Death (Check only sing Home 5 Res	sidence 6 A		otel Room
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director.	Certification;	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be	4 Unknown	neet, factory, office	<br Yes 2.∏χNo	28f. Location	(Street and I own, State)		al Route Number,
	he Hospit in 24 hours he Funere pletely fille	edicai		Physician: To the best of rixaminer: On the basis of examiner state	camination and/or in	nvestigation, in my o	pinion, death		, date and pl	ace, and due t	o the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier	1, M)		29c. Licenson	number	4	-	signed (Month,	
	4		30. Name and address of person v	Mp Union	n Hospit		on, /	77.2192	-1		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 1	5 2004 32. Registrar's	s Signature	Joseph					

			1 - For State Registrar	State o	f Marylar		artmen tificat			ind M		giene ,	2001	035	594
			Decedent's Name (First, Middle, La	st)							2. Date of Dea	ath	V	3. Time of	Death
	Physicia /Medic		Virginia Dare B	rown							January	7	$2004^{^{Yeer}}$	10:10	О Ам
	Examin		4a. Facility Name (If not institution, giv	e street and nur	mber)				Location of	f Deeth		4c. C	County of Dea	th	
			Regency Park Ass					bril.						ndel Co	
	Funeral		5. Social Security Number 6. S	ox □M 2⊋F	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	h y, Year)	9. Bir	thplace (State of cuntry) rth Caro	r Foreign
	Director		578-20-7761 Usual Residence of Decedent	X	84	113.					Sept. 1	.o, 1	919 NO	rtn Car	orina
4	***		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	ty Limits
Mod	man)	to	MD Calvert	Co.	Che	sapeake	e Bea	ch						1 ∑Yes	2 🗆 No
4	or 28g	lrec	10e. Street and Number				10f. Zip					10g. Citiz	en of What C	ountry?	
4	23a	Funeral Director	4001 Band Shell	Court			20	732				U.	S.A.		
6	E L	ne l	11. Marital Status	Armed Fo		.S. 13. V	Nas Deced	ent of His	spanic Orig n, Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	1.	4. Race - Am Black, Whi		
	ori	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, Giv Year or D	/8	1	I □ Yes	2 🗓 No	Specify:			5	Specify: Wh	ite	
3	"natural", or itema 23a or 28a-1 show	edt	15. Decedent's E		a163.	16a. Deced	lent's Usua	ıl Occupa	ation			16b. Kind	d of Business	/Industry	
ה ה	e u	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1	1-4015+1	(Give life. L	kind of wo	rk done d se retired)	luring most )	of workii	rg g			,	
7	giene giene er tha	Completed	12	College (		Telep	phone	Ope:	rator			Fede	ral Go	vernmen	t
III Z I Z I Z-UO30	al Hy d othy	Be	17. Father's Name (First, Middle, Last,								(First, Middle,		lumame)		
2 2	and Mental Hygiene. is marked other than aumatic event, the M.	2	Joseph Milton Her								e Daugh				
-	peniur. Tages i and a should be mad whin Dopartment of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other treumatic event, the Mones.		19a. Informant's Name/Relationship ( Karlene V. Rosasco	* .	hter)						<sup>I Route Numbe</sup> esapeak			Zip Code) D 20 <b>7</b> 32	
- עב	of Head		20a. Method of Disposition	ID		Place of Dispos cemetery, cren	sition (Nam	ne of ther place	e) .T.	anua	ry 26,	20c. Loc	ation - City or	Town, State	
	nages ment of h ant: If Ito ury or o		1   Burial 2 □ Cremation 3 □  Other (Specif		Ar	lington			1 Cem	. 2	004			Virgin	
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Depart Import any inj		21. Signature of Funeration ace Liver	1500										vert, P	
u .	705 g a		Market VI										Owings	, MD 20'	
P	hysician		23a. Part i. Enter the disease, or €m shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on e	eaused the deat each line.	n. Do not ente	fr the mod	e of dying	g, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Bety Onset and D	veen
	/Medical xaminer		resulting in death)	a. Due to	or as a conseq	uence of):	4 10	4.1	0	~ /					ſ
is.	.xammei	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	uence of):	yr/t	7	PO	Pas	t			Tyear	7
1	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,	(		,							
orou,	ohysician and the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):								-	
מל מל מל	hysicii he bu	dlcal	(	d											
Š	attending pt	Med	IF FEMALE:	20. 1/											
	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	I death 3	Ectopic pr					23	ld. Date of de Month	,	ear
j	the ched	Physiclan/Me	1 ☐ Yes 2 <b>Ø</b> No 9 ☐ Unknown	9□ Unkno	ant at time of down	eath 5	Other (sp	өспу)		-					
	signed by the attendin		Part II. Other significant conditions of	ontributing to di	eath but not res	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of de	eath?
The law requires that the death couling	in sign	ed by									1 □ Y	es 2 🗖	No 3 □ P	obably 4 🗆 U	nknown
ט פֿ ט פֿ	s been s	plet									24a. Was a		24b. Were at	itopsy findings a	vailable
	ate has	Completed									autop perfor	med?	death?	completion of ca	luse of
110	certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or				
Di VIIA	this c	2	1 ☐ Yes 2 ☐ No			ER/Outpatien			4 Nur		ne 5 🗆 Resid			cify)	
	After	lon:	27. Many of Death  1 Natural 5 Pending		th, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ′es 2.⊟N		8d. Describe h	ow injury	occurred		
101	after death. Director: After in by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At he	ome, farm, stre			03 2		8f. Location (S	treet and	Number or Ri	ural Route Numb	DB/.
	after Dire	Certification:	4 Homicide determined	buildi	ng, etc. (Specif	y)	,	,			City or Tow	n, State)			-
DIVISION OF Attending	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the ba	asis of examina	wledge, death	occurred estigation,	at the time in my op	e, date and inion, death	place, a	nd due to the o	ause(s) a date and p	nd manner as	steted. to the cause(s)	
d d	ithin i	Med	29b. Signature and Hile of certifier	and mani	ner stated.		290	License	number		2	29d. Date	signed (Mont	h, Day, Year)	
F	5 → 5		> Elliott &	Lat in	D			12	1009	1		oil	09/14		
			30. Name and address of person who	completed caus	se of death (Item	n 23a) (Type J	Print)	1	VIA	<i></i>	Cla	01	1	1	. ,
	10		Elliott Gorl	sety UD,	1411	Medi	Ja	far f	- 1/1	ive,	CYCA	יזטע	TIP ME	1,2106	
	Sta Registr		31. Date filed (Month, Day Year)  JAN 0	9 2004	egistra s Signa	ture #	Sus	the		,			,	1	(

		1 - For State Registrar			artment of rtificate of			eg. No. ZUU	L 03595
Physic /Med		Decedent's Name (First, Middle, La     Herbert	•	Byrd			2. Date of Dea Month January	Day Yea	3. Time of Death
Exam		4a. Facility Name (If not institution, giv 7808 Lakeshore Dr				or Location of D wings	eath	4c. County of De	
Funera Directo	_	379-09-6932	ex 7. Age	(In yrs. last birthday 83 Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Dey Aug. 27,	Yeer)	hirthplace (Stete or Foreign Country) NNESSEE
the Maryland 28e-f ehow	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Calvert  10e. Street and Number	-	10c. City, Town or L Owings	ocation			Og. Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Iryland 21215-0036  should be filed within 72 hours after death with the Maryland to Mentai Hygiene.  marked other then "natural", or itams 23a or 28e-f show marked other than "natural", or itams 22a or 28e-f show marked other than "natural".	Funeral	7808 Lakeshore I	12. Was Decedent E Armed Forces? 1 X Yes 2 N	ver in U.S. 13.	20		? (Specify Yes or No- uerto Rican, etc.)	U.S.A.  14. Race - An Black, Wh	nerican Indian, nite, etc.
215-0036 ithin 72 hours af nen "natural", or a Madical Exam	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gra  Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retin	ipation during most of ed)	working	Specify: W	ss/Industry
ed ig b	To Be Cor	12 17. Father's Name (First, Middle, Last) Lee M.	Byrd	met	al lathe	_	Name (First, Middle, i		ction Gray
Ma nd 2 s alth ar 27 is r trau		19a. Informant's Name/Relationship ( Rose A. Byrd, with	e	7808	Lakesho		Wings, MD	20736	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: eny injury or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☑ Other (Specif	y)	Resurrec	matory or other pla tion Ceme	etery 1/		Clinton,	
Depar Impogra		21. Signature of Funeral Service Licer	P. The	R		neral Ho	ome, P.A.,		
box 68/60, death cartificate be executed death cartificate be executed  e attending physicien and dor use as the burial-transit	I,	23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c.	ATION1	PNEUmo	NIA	LLMONAR		Approximate Interval Between Onset and Death
Geath certific death certific e attending pod for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date of d Month	elivery Day Year
<u> </u>	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	underlying cause g	iven in Part I.			to the cause of death?  Probably 4 □Unknown
	Completed	AS b us +8515					24a. Was a autops perform	ry prior to death? 2 ₹No 1 ☐ Ye	autopsy findings available completion of cause of
Vit rsicia s cente	To Be	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3 DOA	thor	Death (Check only on g Home 5 <b>2</b> Reside	-	nacifu)
DIVISION Of VITAI Hospitel or Attanding Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director;	ertification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 28b. Time o	of 28c. Inju		7	ow injury occurred	ocity
DIVISION Attenuts after deathral Director:	O	3 Suicide 6 Could not b determined	building, etc.				City or Towr		
To the Hospitel of within 24 hours a To the Funeral Completely filled in the Funeral Completely fil	Medical	(Check only 2 Medical Exer	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	ivestigation, in my	opinion, death o	ccurred at the time, d	ate and place, and du	ue to the cause(s)
To with	×	29b. Signature and title of certifier  Attu	m			10370		9d. Date signed (Mor	
15+1		30. Name and address of person who Peter L. Wisniews	ki, M.D. 1	10 Hospita		310, Pri	nce Freder	rick, MD 20	0678
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registra	s Signature	houth !	<b>3</b>			

		For State	State of Ma	aryland /		ent of Health an	d Mental Hy	/gien	eznni.	03500
		Registrar  1. Decedent's Name (First, Middle, I	ast)		Certifica	ate of Death	2. Date of D	Reg. No	o. C. O O H	3. Time of Death
Physici		RONALD F. CAS					Month	Da	y soof	0040M
/Medio Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. Ci	ity, Town, or Location of D	eath.	-	c. County of Beeth	
		5. Social Security Number 6.	Sex 7. Aq	e (In yrs. last b	irthday) If Und	SAL/364 der 1 Year   If Under 24	/	irth	Wicon	nplace (Stete or Foreign
Funeral Director		219-48-8927 Usual Residence of Decedent	10 M 2□F	58	Yrs. Month		8/28/	1945	Kan	untry)
nd Mental Hygiene. i marked other than "natural", or items 23e or 28a-f ahow umatic event, the Micdical Exertities mart be nutified at		10a. State 10b. County		10c. City, Tox	wn or Location					10d. Inside City Limits
8a-f a	Director	MD Worces	ter	Pocom	oke Ci					1 Yes 2 No
Department of Health and Mental Pryglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show supportant: if item 27 is marked other than "natural", or item 23a or 28a-f show supportant in the profile of the profile o	al Dire	10e. Street and Number 414 Cedar Sti	eet		1	Zip Code 851		USA	itizen of What Cou }	untry?
tems BLTs	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was De If Yes, s	cedent of Hispanic Origin' pecify Cuban, Mexican, P	? (Sp <i>ec</i> ify Yes or Nuerto Rican, etc.)	0-	14. Race - Amer Black, White	
ral', or i Exemi	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 X Yes 2 ☐ 1 If Yes, Give Year or Dates:	no Armu	1 ☐ Yes	25 No Specify:			Specify: Wh:	ite
dical	eted	15. Decedent's (Specify only highest of	Education		(Give kind of	sual Occupation work done during most of	working	16b. l	Kind of Business/li	ndustry
then.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		nginee			Gov	ernmen	+
ent, I	Be Co	17. Father's Name (First, Middle, La	st)				Name (First, Middle			
arked atic e	To B	Frank Castaned	la				is Hamby			
27 is m or traum		19a. Informant's Name/Relationship Gina Hutchinso		er 1	b. Mailing Addre	ess (Street and Number of Terusalem l	r Rural Route Numb Rd., Ten	per, City	or Town, State, Zi Cancevi	ip Code23442 lle, VA
or other		20a. Method of Disposition  1  Burial 2 Cremation 3		cemete	of Disposition (A	or other place)	Date 1 / 2 1 / 0 /		_ocation - City or T	
inlury		* 4 □ Donation 5 □ Other (Special Service Lice		Sall	1	Crematory and Address of Facility	1/21/04	Sa	lisbury	y, MD
en g		23a. Part1. Enter the disease, or co	M		Hollo	way Melson			•	A. MD 21851 Approximate
		shock, or heart failure. List on	nplications that caused y one cause on each lis	the death. Do	not enter the m	node of dying, such as car	diac or respiratory	arrest,	7 7 7	Approximate Interval Between Onset and Death
sician edical		Immediate Cause (Final disease or condition resulting in death)	a. Massi	o Vulm	onary &	Emboli				
iner		Date No. 100 A DATE OF THE STATE OF THE STAT		a consequence	or):					
=	mlner	Faquentially list conditions, if any, leading to immediate cause. Enter Underlying	U.	a consequence						
-trans	Exam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	Heart Tack	une i				
sician e buria			Due 10 (01 as	a consequence	, 61).					
ng phy as the	fedic		· ·							
been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat	h 3⊟Ectopic 5⊟ Other (	c pregnancy (specify)			23d. Date of deliv Month	rery Day Year
ned by detac	y Ph	Part II. Other significent conditions	contributing to death b	ut not resulting	in the underlying	g cause given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
en sig							_ 1 🗆	Yes 2	2□No 3□Pro	bably 4 Unknown
S C1	Completed						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
certificate has rector, page 2	Соп						1 Yes	ormed?	death?	2 No
ector	Be	25. Was case referred to medical examiner?	Hospital:	-		0.0	Death Check only			7
r this aral di	. To	1 ☐ Yes 2 No 27. Magner of Death	28a. Date of Inju	ry 28b.	utpatient 3	DOA 4 INUISIN	ng Home 5 ☐ Res 28d. Describe			fy)
After	atlor	Natural 5 Pending 2 Accident investigat	(Month, Day		Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			.,	
_ o	Certification;	3 Suicide 6 Could not 4 Homicide determine		ury - At home, f c. (Specify)	arm, street, fact	ory, office	28f. Location City or To	Street al	nd Number or Run e)	al Route Number,
Director: in by the	(A)	29a. Certifier Certifying	Physician: To the best of	of my knowledg	je, death occurre	ed at the time, date and plion, in my opinion, death o	lace, and due to the	cause(s	s) and manner as s	stated.
uneral Director: aly filled in by the		(Check only 2 Medical Ex		ited.		,, op.,,,,,		dato an	ia piaco, aria aco i	0 110 00030(3)
the Funeral Director: mpletely filled in by the	edical	(Check only 2   Medicel Ex	and manner sta			29c. License number		29d Da	ate signed /Manth	Day Yearl
tor:		(Check only 2 Medical Ex	and manner sta		2	29c. License number			ate signed (Month,	
To the Funeral Director: completely filled in by the	edical	29b. Signature and title of certifier	tiny M.D.	eath (Item 23a)	(Type, Print)	D59568				
To the Funeral Director.	edical	(Check only 2   Medicel Ex	completed cause of d	eath (Item 23a)		D59568	SA L186			

			. For	State of Marylan			lealth and Me		3	. 0050-
			- State Registrar		Cer	tificate of		Reg.	. No.	4 0339
À	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last     Aa. Facility Name (If not institution, give)	FRANCI.	5	Ab. City, Town, or	Location of Death	2. Date of Death Month	Day Year 4c.)County of Dea	3. Time of Death
	Funeral Director		5. Social Security Number  216-76-7981  Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		B. Date of Birth (Month, Day, Ye Aug. 1,		rthplace (State or Foreign country) shington, D.
	a-f show	ctor	10a. State 10b. County  MD Calver		y, Town or Loo Lusby	cation	-			10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	I Director	10e. Street and Number 7850 Pine Blvd.			10f. Zip Code 2065	7	1 -	. Citizen of What C Jnited St	•
036	be filed within 72 hours after deeth with the Maryland ntal Hygiene. ed other than "natural", or flems 23a or 28a-f show event, it a Medical Esta idner mant be multipled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	ispanic Origin? (Specin, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho sne. Ihen "natur in Medical	Completed by	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occup. kind of work done of OO NOT use retired Worker	ation during most of working 1)	1	b. Kind of Business	s/Industry astruction
Maryland 2	be filed ital Hygi of other event, I	To Be Co	12 17. Father's Name (First, Middle, Last) Louis Copsey	<del>-</del>	HOII	MOLVET	18. Mother's Name ( Evelyn		iden Sumame)	isci uccion
Mary	nd 2 should be lih and Menta 27 Is marked r traumatic ev		19a. Informant's Name/Relationship (T) Laurie J. Copsey				and Number or Rural I			Zip Code)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition  1   Magurial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State Mt	emetery, crem • Harmo		Dai C. Cem. Jar	1.26,2004		MD
Ba	permit Depart Import any in		21. Signature of Film ral Se vicy Licens	MO 1095						.c, MD 20676
No. of the last	Pnysician /Medical Examiner		23a. Part. Enter the discase, or bono shock, or hear fai are. List only o Immediate Cause, Final disease or conditi resulting in death)	a. Due to (or as a consequence	uence of):		g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
3	*T25	iner	Scuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	The second secon	umonia				3weeks
,097	ate be executed nysician and he burial-transit	cal Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequent Aspergillu	,					3 weeks
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	I death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	nlivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con Liver failure	-, Rened		.1.	econolary		/	o the cause of death?
Vital Records,	: The law recate has been page 2 sho	Completed	to Renal fail	lune				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vita	sician	o Be	25. Was case referred to medical examiner?	Hospital:	FB/0	art pos Othe	26. Place of Death (			
Division of	anding Physician: The lath. or: After this certificate ha	$\vdash$	27. Manner of Death  1 X Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4   Nursing Home	d. Describe how i		ocify)
DIVIS	al or Attend s after death st Director: , sd in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office	28	f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1X Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inve	occurred at the timestigation, in my or	ne, date and place, and pinion, death occurred	d due to the cause at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
)	To the Comp	ž	29b. Signature and title of certifier	the , no		29c. License	number -000		Date signed (Moni	
	18		30. Name and address of person who co		23a) (Type, F		Street Ba	Himore	MD ZIZ	87-9106
	Sta Registr	ar	JAN 2 8 2004	32. Registrar's Signa	dock.	,				
υH	MH 17 Rev 1/20	JU1	*							

ORIGINAL

			1 - For State Registrar	State of M	laryland	-	artmen rtificate					Reg. N	2001	03	3598
	Physici	an	Decedent's Name (First, Middle, La	st)							<ol><li>Date of De Month</li></ol>		ay Year	3. Time	of Death
	/Medic		Amelia Baer Cress				1 0				Januar		2004	1:	50 A <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, giv	e street and number	")				Location of	or Death			c. County of Death		
			Gilchrist Hospice 5. Social Security Number 6.5	Sex 7. A	ge (In yrs. lasi	t birthday)	Tows:		If Under	24 Hrs.	8. Date of Bii (Month, Da		Baltimore 9. Birth	place (State	or Foreian
·	Funeral Director			I□M 2XDF	85		Months	Days	Hours		(Month, Di May 22			intry) Isylvai	
			Usual Residence of Decedent								,		10 110111		
	show	<u>.</u>	10a. State 10b. County		10c. City, T	fown or Lo	ocation							10d. Inside	City Limits s 2X No
	the Marylar 28a-f show	ecto	Maryland Howard		Ellic	ott		- 1				10.0			3 2 <u>A</u> _110
	with th	D.	10e. Street and Number				10f. Zip						itizen of What Cou	untry?	
	eath w	eral	3165 Sonia Trail	12. Was Deceden	t Ever in U.S.	13.	210		spanic Ori	gin? (Spec	of Yes or No	USA	14. Race - Amer	ican Indian,	
10	r Iten	Fun	1 Never Married 2 Married	Armed Forces	?	1				, Puerto P	ofy Yes or No lican, etc.)		Black, White	, etc.	
93	ral', o	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2LX No	Specify:				Specify: Whit	e	
21215-0036	within 72 hours after death with the Maryland one. than 'natural', or items 23e or 28e-f show the Madical Examination much be rediffed at	Completed by Funeral Director	15. Decedent's E (Specify only highest gra	ducation ade completed)	1	16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa	ation during mos	t of workin	g	16b. I	Kind of Business/f	ndustry	
121	nithin ne. han	mpi	Elementary/Secondary (0·12)	College (1-4or								_	<b>-</b>		
	filed withi Hygiene. other than		12 17. Father's Name (First, Middle, Last	)	l R	lesid	ent Ma	anag		r's Name	(First, Middle		l Estate		
ano	d be	o Be	Kurt Paul Baer	,							n Knapj		,		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms	ဥ	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Address	(Street a					or Town, State, Z	ip Code)	
	1 and 2 s Health ar em 27 ls other trau		Khristine C. Leach	h/granddau	ighter	3165	Sonia	a Tr	ail E	11ico	tt Ci	ty,	MD 21043		
Jre,	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If Item 27 Is marked other than "natural" or Items 23s or 28s4 show or other traumatic event, The Medical Examinating Francisc Conflict at		20a. Method of Disposition	D-marrel from Chate	20b. Plac	e of Dispo	osition (Nan	ne of ther plac	e) J	anuar	y 19,	20c. l	ocation - City or T	Town, State	
Ē	Page nent: if ent: if ury o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		9		Cremat			200		Ba1	timore,	Mary1a	and
Baltimore,	permit. Pages 1 am Department of Heali Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service Lice	nsee //	14010	G	2. Name an	d Addres	s of Facilit	y atior	Serv	ice	P.O. Box	784	
	40 5 # O		Bevery J. He	Kalle-	MO12	DI B	everl	y L.	Heck	rotte	P.A.	C1	arksvill	e, MD	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each	line.		ter the mod	e or dylli	y, such as	Cardiac or	respiratory a	111651,		Approxima Interval Be Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		nent									yea	25
	Examiner		•	Due to (or a	s a consequer	ice oi):									
		Jer	Sequentially list conditions,	b. Due to (or a	s a consequer	nce of									
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
, 0	e exe ian a urial-l	EX	resulting in death) Last	Due to (or a	s a consequer	nce of):							- 11		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		_ d											<u>.</u>
9 X	eath certific attending p I for use as t	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnance	v							23d. Date of deli	1001	
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant :	2 Fetal de	ath 3[	⊒Ectopic pr ⊒ Other <i>(sp</i>						Month	Day	Year
P.O.	the d by the achec	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
	res that the de signed by the a be detached t	by P	Part II. Other significant conditions	contributing to death	but not resulting	ng in the u	inderlying c	ause give	en in Part I.		23e. Did	tobacco	use contribute to	the cause of	death?
Records,	w require been sig should b										10	Yes 2	2 No 3 □ Pro	bably 4	]Unknown
S	e law re has be je 2 sh	Completed									24a. Was		24b. Were aut	opsy finding	s available cause of
<b>E</b>		Con									perfe	ormed? 2 <del>S</del> N	death?	2□ No	
Vital	ding Physician: Th h. Atter this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Ho opital:		_		0#		of Death	(Check only	one)	resule:		
of	Physic this c	- To	1 Yes 2 No	Hospital: 1 ☐ Inpat 28a. Date of In		VOutpatie		-	4 🗀 Nu	_	e 5 Resi	-	ther (Spec	in) Ites	PICE
on	Jing After fune	tion	1 €Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	M	8c. Injun Worl	γατι ∢? Yes 2∐i		ou. Describe	now my	ary occurred		
Division	Attending r death. ector: After you the fune	flca	3 Suicide 6 Could not b	28e. Place of Ir	njury - At home	e, farm, st	reet, factory	, office		2	8f. Location (	Street a	ınd Number or Rui	ral Route Nu	mber,
ē	s after	Certification;	4 - Homicide determined	building, e	etc. (Specify)						City or To	wn, Stai	(e)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying P	hysician: To the bes miner: On the basis	of examination	edge, deat	h occurred	at the tim	ne, date an	d place, ar	nd due to the	cause(	s) and manner as	stated.	(e)
	the H in 24 the Fi	Medical	one)	and manner s	stated.	- and/or in				0000110	at the lime,				(3)
	with To t	Σ	29b. Signature and title of certifier	02					number	*2			ate signed (Month	-	
	(2) a		THE	er my			1	) >	0 50	) >		JA	WARRY !	coay	
	Glad		30 Name and address of person who	completed cause of	death (Item 2)	3a) (Type	Print C	mla	2 6	+ Bo	1 tenor	ve i	NUARY 17	104	
	Sta	ite	31. Date filed (Month, Day, Year)	7	trar's Signatur	θ,									
	Regist		IAN 2.1	2004	due 1	de 1	books	1							

Cressman, Amelia 1/17/04 1:50 Am

DHMH 17 Rev 1/2001

ORIGINAL

## **VOID**

# **CERTIFICATE** #

2004 -03600

## SEE

CERTIFICATE #

2004-Gotal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar item #5 1/28/2004, E.T. Certificate of Death WCHD **Amended** 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 01/24/2004 **Physician** Marie Elizabeth Disbrow 2:45 AM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 157 Oyster Lane Ocean City

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 💢F 334-34-1432 09/19/1940 63 ĬĬĬinois Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Worcester MD Ocean City Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ death with 157 Oyster Lane 21842 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is merked other than any injury or other traumatic event, Intal once. Teller Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marvin Hurley Martha Schmitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Warren Disbrow (husband) 157 Oyster Lane Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 01/28/2004 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William Street Berlin, MD 21811 23a. Part1. Enter the disease, or composhock, or head failure. List only o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cations that Immediate Cause (Final disease or condition resulting in death) Physician OVARTAN CARCTNOMA a. Metastatic 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and ned for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached in 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 ☑Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mas

Registrar DHMH 17 Rev 1/2001

State

29 BroadstReet

D005499

Bertin

1127/04

21811

MD

MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

W. ELLIS

JAN 2 7 2004

31. Date liled (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 10,2004 **Physician** Evans 9:54 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Mariner Health of Southern Maryland Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 73 Director 416-40-6358 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Maryland Prince Georges Clinton 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Itams 23a or the Medical Examiner must be USA 20735 8600 Mike Shapiro Drive #115 Funera 12. Was Decedent Ever in U.S.
Armed Forces?
1 (XYes 2 | No 1955)
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1955 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1957 1 Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filad within th and Mental Hygiene. ?7 is markad othar than "! Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator Federal Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mattie Day Allen Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If itam 27 is
any injury or other trau 8600 Mike Shapiro Dr. #115 Clinton, Maryland 20735 Alice Evans/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cheltenham, 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland MD Veterans Cemetery 1/20/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Offer Odessa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Respiratory Arrest **Physician** /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease
Due to (or as a consequence of): scushing ist anothers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit that the death certificata be executed H rtension Due to (or as a consequence of): Box 68760, Physician/Medical Hyperlipidemia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detachad 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Status Post CVA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Obesity autopsy performed? certificate Dementia, Feeding Dysfunction 2 □ No 1 ☐ Yes 2X No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certifics completely filled in by the funaral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 XNursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Valenti Castin DC 5078 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert S. Castrence, M.D. 4302 St. Barnabas Rd Ste B Temple Hills, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 2004 Registrar

		_	For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene Reg. Ne	CUI	04	036	503
			1. Decedent's Name (First, Middle, Last								2. Date of De	ath Da	av.	Year	3. Time o	
	Physicia /Medic		JOHN LAWER	ENCE C	IBSO	N				JAN	UARY_	31	200	4	6:50	A M
-	Examin		4a. Facility Name (If not institution, give		_				Location of	of Death			c. County			
			Frederick Memoria		1		Fred						reder			
	Funeral Director		220-36-4022	7. Ag	e (In yrs. las 61	Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 30	y, Year	942	9. Birthi Coul West	olace (State otry) Virg	or Foreign inia
	g .	-	Usuat Residence of Decedent  10a. State 10b. County		10c. City.	Town or La	ocation							Ţ.	Od. Inside C	ity Limits
	aryla sho	5			Kensi										1X Yes	2 No
	788-1	ect	Maryland Montgome:	ГУ	Kensi	ington	10f. Zig	Code				10a. C	itizen of W	hat Cou	ntry?	
	with a or	۵	4119 Warner Stree	Ė			208					USA				
	ns 23	era	11. Marital Status	12 Was Decedent	Ever in U.S.	13.1			spanic Ori	gin? (Spe	icify Yes or No Rican, etc.)		14. Race		can Indian,	
	fter d	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼	No						Hican, etc.)	1		k, White,	etc.	
200	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 <u> X </u> No	Specify:				Specify:	Whi	ite	
21215-0036	be filed within 72 hours after death with the Marylan de Hygiene.  I al Hygiene.  I other than "natural", or Items 23a or 28a-f show event, the Medical Examination must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)		16a. Dece	dent's Usu kind of wo	al Occupa	ation <i>Juring m</i> os	t of worki	ng	16b. I	Kind of Bu	siness/In	dustry	
2	ithin 98.	nple	Elementary/Secondary (0-12)	College (1-4or												1 .
2	filed wi Hygien ther th	S	12		M	laster	Mec.	hanio		arla Mama	(First, Middle				ealer)	sh1p
בַ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens.  and Mental Hygiens.  and Mental Hygiens.  and marked other than "natural", or tlems 23a or 28a-f show as marked other than "natural", or tlems 23a or 28a-f show as urnatic event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last) French Gibson								Jean Ho		ii Sumanii	6)		
2	d Mer narke	2	19a. Informant's Name/Relationship (7	una Print)	T	19h Mailir	na Address	Street a			l Route Numb		or Town	State. Zir	Code)	
Maryland	d 2 st th and 7 is r traur		Nancy J. Gibson,				-				sington				20895	
	1 and Health Iem 27		20a. Method of Disposition	WIIC	20b. Plac	ce of Dispo	osition /Na	me of			ate				own, State	
2	Pages nent of int: If It iry or o		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		hsbur	-			2/3/2	2004	Smi	thsbu	ırg.	Mary1	and
Baltimore,	# 문문공 .		21. Signature of Buneral Service Licens		1		_				ney and					
Ba	Depa Impo sny ii		1 Jan My +	Dunen	м0099						eet, Fr				2170	
	(c)		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	d the death.	Do not en	ter the mo	de of dyin	g, such as	çardiac c	r respiratory a	rrest,			Approxima Interval Be	ite itween
P.	Physician		Immediate Cause (Final disease or condition		1600										Onset and	Death 1
*	/Medical		resulting in death)	Due to (or as	a conseque	ince of):	6 10		3 · (· ·	- Carrie	1					
Q 3	Examiner		Sequentially list conditions	b												
-	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ince of):										
)	ecute and trans	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	nce of):										
760,	ate be executed hysician and the burial-transit	al E		D00 10 (01 as	a conseque	nico orj.										
$\infty$	death certificate be executed e attending physician and of for use as the burial-transit	dical	•	d												
9 xo	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date	e of deliv	ery	
B	atter for t	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			_Ectopic p ☐ Other (s						Mor	nth	Day	Year
o.	the d by the	nysl	9 Unknown	9□ Unknown							T .					
a,	uires that the der signed by the a Id be detached f	by Pi	Part II. Other significant conditions co	ontributing to death t	out not result	ting in the u	underlying	cause givi	en in Part I	l.	23e. Did	tobacco	use contr	ibute to t	he cause of	death?
rd	w require been sig should b	ed t									1 🗆	Yes	2 0	3 Pro	bably 4	]Unknown
Records,	law re	Completed									24a. Was		24b. V	Vere auto	opsy findings impletion of	available cause of
	The I	EO										ormed?	_ 0	leath?	2□ No	
ita	ician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?						26. Place	e of Death	(Check only	one)				
<u>&gt;</u>	hysic his ce I dire	101	1 ☐ Yes 2 No	Hospital:		R/Outpatie			4 🗀 191		me 5 Res				fy)	
ū	ding Physician: The Ih. After this certificate ha funeral director, page	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Inj (Month, Da	ury ay Year) 2	28b. Time o Injury		28c. Injun Wor			28d. Describe	how inj	ury occurr	ed		
Division of Vital	death. ctor: A the fu	cat	Accident investigation 3 Suicide 6 Could not be		ium. At hom	an form of	M (a ata		Yes 2 🗆		28f. Location	(Street a	and Numbi	ar or Rur	al Route Nu	mher
<u>.</u>	of or Attendated after death Director:	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify)		reet, racto	y, office			City or To	wn, Sta	te)	o, o, , , <sub>0</sub> ,	277100101140	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funerel Director: After this certificate has been signed by th completely filled in by the funeral director, page 2 should be delached.		29a. Certifier Certifying Ph	ysician: To the bes	t of my know	ledge, dea	th occurred	d at the tin	ne, date ar	nd place,	and due to the	cause(	s) and ma	nner as :	stated.	
,	To the Hospital within 24 hours To the Funerel completely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner s	of examination	on and/or in	nvestigatio	n, in my o	pinion, dea	ath occurr	ed at the time	, date a	nd place, a	and due t	o the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertifier				29	c. Licens	e number			29d. D	ate signed	(Month,	Dey, Year)	
			Yearly	w ui				1)00	3/05	D		. 0	1-3-	04		
	5		30. Name and address of person who	completed cause of	death (Item 2	23а) (Туре	, Print)	1	/ [.	. ,	poro		, .	3/3	00	
-	ر		Gone Arwas	10200	(011		111	1	. 41	14/11	DUN	MI	) 0	11/	18	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	trar's Signatu	J.S	Land	12 M. D	}							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jason Daniel Gearing JANUARY 10, 2004 0821 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2001 DARES BEACH ROAD PRINCE FREDERICK CALVERT If Under 1 Year If Under 24 Hrs. Months Days Hours Min. August 6 1981 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1X M 2□ F 22 Yrs. Director 216-21-3171 Washington, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, it a Modical Examinar must be notified at Director 1 ☐ Yes 2X No Calvert Prince Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 Dares Beach Road 20678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 □ Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 hand Mental Hygiene.
7 Is marked other then "r Efementary/Secondary (0-12) Colfege (1-4or 5+) 12 Cook Resturant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Ernest Michener Gearing Patricia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is James F. Cornette, Sr (Step-Father) 2001 Dares Beach Road Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 16 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or \*4 □Donation 5x Other (Specify) Entomb Resurrection Cem. 2004 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Duce. Cary J. Goth 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intraoral Shotgun wound disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-Due to (or as a consequence of): sician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy jo in the past 12 months? Month 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No Pe ( 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 99 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 🗖 (No Completed peen 24b. Were autopsy findings available prior to completion of cause of deatb?

1 2 4 es 2 1 No 24a. Was an page 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 XYes 2 No Be 26. Place of Death (Check only one)

**Physician** /Medical Examiner

within 72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,

o

Δ.

Records,

of Vital

Attending Division

ō

the

certificate be

this certificate has After the

death. within 24 hours after deat To the Funerel Director: in by

P

Medical

Certification: 1 Natural 2 Accident

29a. Certifier

3 Suicide 4 ☐ Homicide

27. Manner of Death 5 Pending investigation 6 Could not be determined

-10-04

Hospital:

28a. Date of Injury 28b. Time of Courty 28c. Injury at Work?

8:15x M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) nome at

1 | Inpatient 2 | ER/Outpatient 3 | DOA

1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE 28d. Describe how injury occurred Subject shot

Fred

selt 28f. Location (Street and Number or Rural Route Number City or Town, State) 300 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier

29c. License number OCME

29d. Date signed (Month, Dey, Year) JANUARY 11, 2004

39-Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21201

FONICA 31. Date filed (Month, Day, Year)

32. Registres Signature

Registrar

State

			For Stete Registrar	State of M	laryland		artment tificate			and M		Reg. No.	2004	03605
Н	Physici	373	Decedent's Name (First, Middle, Last	st)							<ol><li>Date of De. Month</li></ol>	ath Day	Year	3. Time of Death
	/Medic		PAULINE RUTH								01	14	2004	14:24p M
4	Examin		4a. Fecility Name (If not institution, give		7)				Location o				County of Dea	
			Hartley Hall Nursi 5. Social Security Number 6. S		ge (In yrs. last	t birthdav)	Pocon If Under 1	1 Year	If Under 2		8. Date of Birt		Norcest	
	Funeral Director			□м 2 <b>∛</b> Ё F	88	V	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 01/25/	y, Year)	Mar	thplace (State or Foreign ountry) vland
			Usual Residence of Decedent								0.7207		1.20.2	*
	irylan show	_	10a. State 10b. County		10c. City, T									10d. Inside City Limits
	Ba-f s	cto	MD Worceste	er	Pocom	noke (	<del></del>							1 XYes 2 No
	or 2	Director	10e. Street and Number				10f. Zip (					10g. Citi	zen of What Co	ountry?
	s 23a	Funeral	1006 Market Street		A Francis III C	12.1	218		is Orio	-in2 (Can	aifu Vaa au Na		USA 14. Race - Ame	nican Indian
	ltam Itam	in.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐	?	13.	f Yes, speci	ify Cubar	n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, Whit	
36	urs af	by F	3 ☐ Widowed 4 ☼ Divorced	If Yes, Give Year or Dates			1□Yes 2	(XNo	Specify:				Specify: W	hite
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Examiliat must be indiffed at	ted	15. Decedent's Ed (Specify only highest gra	ducation	1	16a. Dece	dent's Usual	Occupa	tion	of worki	na l	16b. Ki	nd of Business	/Industry *
215	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work DO NOT use	e retired)	uning most	Or WORK	''y			
	filed wi Hygien sther th	S	11			Car	egiver	<u> </u>					althcar	e
Maryland	2 should be fited within and Mental Hygiene. Is marked other than aumatic event, the Ms	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Sumame)	
yla	tould I Men narke	ဥ	Edward Colonna	Time (Grint)		10h Mailia	a Address	(Strant o	Ev		ull	- City o	Town State	Tin Code l
Mai	10a. State   10b. County   10c. City, Town or Location   10c. City   10c. Ci													
	1 and Heali tem 2		20a. Method of Disposition	(daugnte	20b. Plac	e of Dispo	sition (Name	e of		D	ate		cation - City or	<del></del>
Baltimore,	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		9		natory or oth			/17/2	004	Paca	moke Ci	tv. MD
Ħ	artme ortan injury		21. Signature of Funeral Service Licer		11130					<u> </u>				.01 / 1.2
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury or other tra		Much OB	Dear		Ho	OZ Lir	ay Me ndan	elson	i Fun	eral Ho comoke	ome, City	P.A.	1851
			23a. Part1. Enter the disease, or com	plications that cause	ed the death. I								Y , 1110 Z	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each	0 444 -	011	Lin							Onset and Death
4	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequen	nce of):								
н	Examiner		Conventially list conditions	b										
	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequer	nce of):								
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										
90,	ate be executed hysician and the burial-transit	Ē	losoning in doubly East	Due to (or a	s a consequen	ice of):								
8760,	¥ > 9	dical		d										
Box 68	leath certifica attending ph	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregnancy	v						2	3d. Date of del	livery
Bo	eath atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 - Fetel de at time of deat	eath 3	Ectopic pre Other (spe					-	Month	Day Year
P.O.	at the de by the	ysi	1 Yes 2 No 9 Unknown	9□ Unknown	- 1			- //						
	that		Part II. Other significant conditions of	ontributing to death	but not resultir	ng in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
rds	w requires that been signed to should be deta	ed b	C. V. A.								101	es 2,1	SoNo 3 ☐ Pr	robably 4 Unknown
000	> 0 %	plet									24a. Was		24b. Were at	utopsy findings available
Ä	The lav	Completed by									perto		death?	completion of cause of 2 □ No
Division of Vital Records,	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1	
<b>Ž</b>	Physician: this certific ral director,	일	1 ☐ Yes 2 ◯ No		tient 2□ER				4)ZNVU		ne 5 🗆 Resid	-		cify)
Ē	ding P. h. After t funera		27. Manner of Death  1   SNatural 5 □ Pending	28a. Date of In (Month, D	jury 28 Pa <i>y Year)</i>	3b. Time of Injury		Bc. Injury Work			28d. Describe h	now injury	occurred	
sio	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not b				M		′es 2□l		205 1 1			
Ξ	or At ifter of Direct in by	it.	4 Homicide determined	286. Place of II	njury - At nome etc. <i>(Specify)</i>	e, farm, str	eet, factory,	office		1	City or Tox			ural Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical Certification:	29a. Certifier 1 12 Certifying Ph	ysician: To the bes	t of my knowle	tech anh	) Occurred o	at the time	e date an	d place	and due to the	Called/e/	and manner as	stated
	24 hos Fun etely	dica	(Check only 2 Medical Exar	niner: On the basis and manner s	of examination	and/or in	vestigation,	in my op	inion, deat	th occurre	ed at the time,	date and	place, and due	to the cause(s)
	Fo the vithin fo the	Me	29b. Signature and title of certifier	0			29c.	License	number		:	29d. Date	signed (Mont	h, Day, Year)
	->-0		1	Just 1	M. D	).		D- 1	546	12:	2		1-14-	-049
	1 -		30. Name and address of person who	completed cause of	death (Item 2	(Type,	Print) ,			Λ.	1	110	1	
<u>C.</u>	11,1		2604 Mar	Ket J+	1	000	mok	2	(	141	) ~	78	> /	
	Sta Registi	_	31. Date filed (Month, Day, Year)  JAN 2 2 2	completed cause of the completed cause of the completed cause of the complete cause of the caus	trar's Signatur	4 9	medi	)						

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State	oi maryia		tificate of	Health and Death	wentai ny	Reg. No. 2	004	03606
			1. Decedent's Nam-	e (First, Midd	le, Last)					2. Dete of De Month		V	3. Time of Death
	Physici /Medi		FERN KA	THRYN	BAKER	HOSTE	TLER			01	Day 16 2	Year 2004	11:25 pm
	Examir		4e Fecility Name (/						4b. City, Town, or	Location of Deat		ty of Deeth	
1			7201 Menr	nonite	Church R	oad			Westover	:	Some	erset	
	Funeral		5. Social Security N		6. Sex	7. Age (In yr.	s. lest birthday)	If Under 1 Yea Months Days			th v. Year)	9. Birthpl	lace (State or Foreign try)
ь	Director		219-34-32		1□ M <b>2</b> 4□ F		66 Yrs.	monano Day		9/16/	1937		/land
	D N		Usuel Residence of 10a. State	Decedent 10b. County		100.0	City, Town or Lo	action				4.	Od Jasida Cita Lineita
	enyla show	ŗ	66.1					cation				10	0d. Inside City Limits 1 ☐ Yes 2X No
	be filed within 72 hours after death with the Meryland tal Hyglene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be nothing at	Director	MD	Somers	set	WE	stover						
	A S	듑	10e. Street end Nur					10f. Zip Code			10g. Citizen of		try?
	ath v	<u>ra</u>	7201 Menr	nonite				21871				USA	
	er de	Funeral	11. Maritel Status		Armed		U,S. 13. V	Vas Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Ha	ice - America ack, White, e	
20	s aft	by F	1 ☐ Never Marri 3 ☐ Widowed		If Yes. C	2. ŽŠNo Give		□ Yes 225No	Specify:		Speci	fy:	
Maryland 21215-0020	hour fural	줐	3 2 111001190		Year or	Dates.	16a Dooos	lent's Usual Occu	unation		16b. Kind of E	whi	
15	in 72	Completed		ify only highe	st grade completed	-	(Give	kind of work done OO NOT use retin	during most of wo	rking	IOD. KING OF	Jusinessind	usiry
12	filed within Hygiene.	Ĕ	Elementary/Seco	ndary (0-12)	College	(1-4or 5+)	Homema				Domes.	+ia	
D	filed Hygi ther	Ö	17. Father's Neme	First, Middle,	Last)		nomenia	rver	18. Mother's Na	me (First, Middle			
an	should be filed and Mental Hygi marked other imatic event, i	To Be	Melvin I						Minnie	Yoder			
<u></u>	d 2 should the and Men 7 is marked traumatic.	F	19a. Informant's Na		thip (Type, Print)		19b. Mailin	a Address (Stree	t and Number or R		er City or Town	State Zin	Code)
E S	d2:d2:d2:d7:is		Norman L			shand)			te Church				
a)	the He	- 1	20a. Method of Disp		SCICI (III	the second secon	Place of Dispo	sition (Name of		Date	20c. Location		
Baltimore,	8 0 <del>- 2</del>		1 Burial 2	☐ Cremation	3 Removal from		-	natory or other pla					
Ħ	permit. Pag Department Important: If any injury o		4 ☐ Donation			Hol	100		Cemetery !	The second second second section is a second			MD
Ва	mpo mpo any i		21. Signature of Fu	neral Service	Licensee			-	Mê156HY Fu				
	40		Olh	had	14 =	Dean	, 10	)3 Linde	n Ave., F	Pocomoke	City, I	MD 218	351
3			23a. Part1. Enter the shock, or hear	ne diseese, or rt failure. List	complications that only one cause on	caused the dea each line.	ath. Do not ente	er the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
· }	Physician	2							16				Onset and Death
	/Medical Examiner	ė,	Immediate Cause ( disease or condition		Me	tostatio	= Ke	nal cel	l Corei	nomo_			5 mo.
	LAdilline		resulting in death)		0	Due to	(or as a conseq	uence of):					
	P #	Examiner			<b>—</b> b							i	
	tificete be executed ig physician end es the buriel-trensit	Cam	Sequentielly list con	nditions,		Due to	(or es a conseq	uence of):					
68760,	sian curiel	m	Sequentielly list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	rlying	2							1	
876	hysic the b	edicai	that initiated events resulting in death) L	ast	Ü	Due to (	or as a consequ	ience of):					
	ing p												
Вох	attendin for use	lan/			d							!	
-	that the death certined by the attending	Physician/M	Part II. Other signifi	cant conditio	ns contributing to	death but not re	sulting in the ur	derlying cause g	ven in Part I.	23b. Did	obacco use co	ontribute to	the cause of death?
P.O.	at the	F								10	Yes 25(No	3 Prob	ably 4 Unknown
	es th igner	þ											
ord	w requires that been signed be should be det	te d									an autopsy rmed?	avai	re autopsy findings ilable prior to
ပ္ပ	has be	P P				-							npletion of cause leath?
of Vital Records,	The law requires that ate has been signed b page 2 should be dete	Completed								101	res 255th	1 🗆	Yes 2□ No
ita	certificate	Be	25. Was case referr	ed to medical					26. Place of De	ath (Check only o	ne)		
<b>_</b>	Physician: this certific ral director.	10	examiner? 1 ☐ Yes 2 🔀	No	Hospitel: 1 [	Inpatient 2	BR/Outpatient	3□ DOA Ot	her: 4 Nursing H	lome 5 Aesid	dence 6 □Otl	ner (Specify,	,
0	g Ph erth neral		27. Manner of Death		28e. Date	of Injury nth, Dey Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe l	now injury occu	rred	
Division	Attending or death. octor: After by the fune	atic	1 Matural 2 ☐ Accident	5 □ Pendin investiç	gation	,	,,		Yes 2 □ No				
<u>Vis</u>	Afte er de ecto by th	E	3 ☐ Suicide 4 ☐ Homicide	6 Could a	ined 289. Place	e of Injury - At I		et, factory, office		28f. Location (S City or Tox		ber or Rural	Route Number,
Ö	s after	Certification:				ang, oto. (opoo				ony or ros	, 0.210)		
	Hospital 24 hours 2 Funeral I	<u>g</u>	29a. Certifier (Check only	1 CertifyIn	g Physician: To th	e best of my kn	owledge, death	occurred at the ti	me, date and place	, and due to the	ause(s) and m	anner as sta	ited.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certification of the Funeral Director. After this certification by the funeral director.	edical	one)	∠ ⊔ medicat	Examiner: On the l and ma	nner stated.	auon end/or inv	estigation, in my	opinion, death occu	irred at the time,	pate and place,	and due to t	ine cause(s)
_	To the within 2 To the comple	≥	29b. Signature end	title of certifie	- 1/	0.		29c. Licen	se number		29d. Date signe		
			Tow		~ · /C	W	_	Door	4314		1119	1000	ナ
			30. Name end addre	ss of person	who completed cau	ise of death (Ite	m 23e) (Type, f	Print)					
D	N. 4		IGNATI	TP	KLUG	. 145 8	= corro	11 Strut	. Salis.	buy, y	ND. 216	04	
-	Sta	te	31. Date filed (Monta		32.	Pegistrer's Sign		·		0			
	Registr	ar		JAN 2	2 2004	CARLACI	15. G	BALL					

			State	partment of Health and Ment Sertificate of Death	tal Hygie	7000	03607
	Physici	an	Registrar      Decedent's Name (First, Middle, Last)  Hattie Elizabeth Elizabeth Hattie Elizabeth Hatti	2. D	Date of Death	Day 2004	3. Time of Death 3:00 A M
	/Medic Examin	w	4a. Fecility Name (If not institution, give street and number) 3251 St. Johns Lane	4b. City, Town, or Location of Death Ellicott City		4c. County of Deeth	
	Funeral Director		5. Social Security Number  213 01 4956  6. Sex 1	ay) If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min.	Date of Birth Month, Day, Yo		nplece (State or Foreign untry) Cyland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any highry or other traumatic event, in Medical Examinar must be notified at any highry or other traumatic event, in Medical Examinar must be notified at ange.	by Funeral Director				United St	cates
0000-01717	ed within 72 hours after ygjene. ier than "natural", or l t, the Medical Exertif	Completed by F	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  HOT	1 □ Yes 2 □ No Specify:  seedent's Usual Occupation live kind of work done during most of working  e. DO NOT use retired)  nemaker		Specify:  ib. Kind of Business/I  Own Home	White ndustry
Tylalia	should be fill nd Mental Hy i markad oth umatic even	To Be	17. Father's Name (First, Middle, Last)  George Cunningham Stump  19a. Informant's Name/Relationship (Type, Print)  19b. M	18. Mother's Name (First Cora Eliza ailing Address (Street and Number or Rural Rose	beth	unknown	ip Code)
nore, ma	Pages 1 and 2 ent of Health a nt: If Item 27 is y or other trai		20a. Method of Disposition 20b. Place of Disposition cametery,	51 St. Johns Lane Elli sposition (Name of crematory or other place) nepherd Cem.  Date 1-21-2	20	ity, MD 2] c. Location - City or 1 Ellicott (	Fown, State
Банито	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee M01044	22. Name and Address of Facility Harry 1112 Old Columbia Pike	H. Wi	tzke's Fam ott City,	nily FH Inc. MD 21043
8/00,	Physician // Medical Examiner pe price pri	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	enter the mode of dying, such as cardiac or res	Spiratory arrest	thy	Approximate Interval Between Onset and Death
J. BOX 6	ie death certificate the attending phys hed for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliment	very Day Year
Vital Records, P.	rsician: The law requires that the death certificate be executed secrificate has been signed by the attending physician and firector, page 2 should be detached for use as the burial-transit	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the	shysema	24a. Was an autopsy performe	24b. Were au prior to c death?	the cause of death?  obably 4 Unknown  topsy findings available ompletion of cause of
DIVISION OT VITAL	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification: To Be C	25. Was case referred to medical examiner?  1	26. Place of Death /Ch.  atient 3 DOA Other: 4 Nursing Home e of y 28c. Injury at 28d. Injury at 7 Nursing Home 1 1 Yes 2 No  street, factory, office 28f. L	neck only one) 5 (XResidence Describe how	ce 6  □Other (Specinjury occurred	
_	he Hospital in 24 hours i he Funeral pletely filled	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, do and manner stated.	eath occurred at the time, date and place, and d or investigation, in my opinion, death occurred at	t the time, date	and place, and due	to the cause(s)
	Tot withi Com	×	29b. Signature and title of certifier  29b. Name and address of page 200 completed course of death (flore 23a) (The	29c License number D 21928	29d	January	
(	y) (jór Sta	ate	30. Name and address of person who completed cause of death (Item 23a) (Ty 3459 St Tohn LN EC. MD 2100 31. Date filed (Month, Day, Vear) 32. Segistrar's Signature	12			
	Regist		JAN 2 0 2004 Stew 15.	Source			

			1 - For State Registrar	State of Mar			leaith and N	Mental Hygi	_	4 03608
	Physici	an	1. Decedent's Name (First, Middle, U Dorothy	Rebecca	Harr	o d		2. Date of Death Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death	January	5, 200 4c. County of De	
	LXaiiii		Solomons Nurs	ing Center		Solo:	mons		Ca1v	ert
	Funeral Director		219-42-4100	Sex 7. Age (	n yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar. 16,	9. B 1922 M	irthplace (State or Foreign Country) aryland
	Maryland I show	tor	Usual Residence of Decedent   10a. State   10b. County	1	Oc. City, Town or Lo	Lusby				10d. Inside City Limits 1 ☐ Yes 21 No
	h with the	Funeral Director	10e. Street and Number 690 Sollers	Wharf		10f. Zip Code 206	57	10	g. Citizen of What (	Country?
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "neturei", or Items 23a or 28a-f show injury or other traumatic event. I've Medical Evantifiar must be notified at injury or other traumatic event. I've Medical Evantifiar must be notified at e.g.	Ď	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🗓 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: B 1	nite, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. kther than "netur snt, tre We licel	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0·12)	Education trade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Housewi	during most of work d)	ring 16	Own Ho	
yland 2	2 should be filed and Mental Hyg	To Be C	17. Father's Name (First, Middle, La Jacob	Coby			18. Mother's Nam Henri	e (First, Middle, Ma .etta		own
	and 2 sho salth and n 27 is mu		19a. Informant's Name/Relationship Hilton Harro	d/Son	P.(	D. Box		Lusby,	MD 2065	7
Baltimore,	Pages 1 ment of Hu ent: If iter ury or oth		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	20b. Place of Dispo cemetery, crer Ernestin	natory or other pla ne Jones	sCem.1/1	0/04 C	_	ke Bch.,MD
Balt	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice  Play A.	Sewell	well Fu Rd.Pri	nera <u>l</u> H nce Fre	ome d.,MD20678			
-	Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the description of the cause on each line.  a.   Due to (or as a company)	iac A	er the mode of dyir	mg, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
760,	te be executed ysician and burial-transit and	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	Clench's onsequence of):	c Cordi	o-Vasu	los dis	Pate	more than 2 years.
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tim 9□Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy	1		23d. Date of d Month	elivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions  Demen Ha	contributing to death but r	not resulting in the u	nderfying cause giv	ven in Part I.			to the cause of death?  Probably 4 ①Unknown
Vital Records,	The law requisate has been page 2 shoul	Completed	_Atrial fibr	110Hon				24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of s
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one)		
of	ng ffer ine	ation: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpatien 28b. Time of lnjury	28c. Injur Wor	y at k? Yes 2 ☐ No	me 5 ☐ Residen 28d. Describe how		ecify)
Division	el or Atters s after dezentel Directored in by the	Certification;	3 Suicide 6 Could not determine	28e. Place of Injury building, etc. (	- At home, farm, str Specify)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical (	(Check only 2 Medical Ex	Physician: To the best of raminer: On the basis of ex and manner stated	amination and/or in	estigation, in my o	ppinion, death occur	red at the time, date	e and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	-c. 6	wana	29c. Licens	50653		1. Date signed (Mor	
	2		30. Name and address of person who 5851 - Dead	e Church	h (Item 23a) (Type, Foil Ro	Print) GYI	AN.C. Deale	SURF	207	15/
	Sta Registr		31. Date filed (Month, Day, Year)  JAN	0 6 200 <b>4</b>	Signature	Soule	•			

			1 - State Registrar	partment of Health and Nertificate of Death		iene 2 0 0 4	03609
	Physici		1. Decedent's Name (First, Middle, Last) Richard Edward Humphreys		2. Date of Deat JMM 11		3. Time of Death 1610P <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Prince Frederi  J If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	4c. County of Death Calvert	place (State or Foreign
	Funeral Director		220 16 8183	Months Days Hours Min.	Month, Day, April 1	0 1928 N	laryland
	ne Marylan Ba-f ahow diffied at	Director	nar 1 range	Frederick		1	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23e or 2 ust be n	ai Dire	870 Main Street	10f. Zip Code 20678		og. Citizen of What Cour Jnited Sta	•
920	ours after dea ral', or Items Examinar m	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify.Whit	etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Important: If ten 27 is marked other than "natural" or items 23e or 28e-f ahow any injury or other traumatic event, I're Madical Eraciner must be notified any once.	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Plum	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ber/ supervisor	ing {	6b. Kind of Business/Ind	•
/land	12 should be file n and Mental Hy Is marked othe raumatic event,	To Be C	<sup>17. Eather's Name (First, Middle, Last)</sup> John E. Humphreys, Sr.	18. Mother's Name Cathe	e (First, Middle, M rine Jo	daiden Sumame) Y	
, Man	and 2 sho saith and I n 27 is me		Aleta Wilde Humphreys- wife 87	1			
imore	Pages 1 ment of He tant: If iter jury or oth			ematory or other place an 15 2 1 U.M. Cemetery	LT POU	oc. Location · City or To Jsby Mary.	land
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rau 05 Broomes Is.	sch Fur Rd. Poi	neral Home ct Republ:	PA ic MD 20676
•	Cate be executed by sician and physician and the print-transit the print-transit print by the pr	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expect the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ner the mode of dying, such as cardiac o	or respiratory arre	St.	Approximate Interval Belween Onset and Death
	death certifi e attending I od for use as	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
rds, P	signed signed d be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
ř	The ate h page	Completed			24a. Was an autopsy perform	prior to con ad? death?	osy findings available apletion of cause of
ō	Attending Physician: The death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?    Yes   2   No	The second secon		ce 6 Other (Specify	)
_	7 to 1	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	a Hox 24 h a Fur etely	ledicai	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, dat	e and place, and due to	the cause(s)
•	To the within To the compl	Σ	29b. Signature and title of certifier	29c. License number 751949  Print)  Print)  Printe  Pr	290	Date signed (Month, E	vay, Year)
	10		30. Name and addless of person who completed cause of death (Item 23a) (Type	u30 Ance F	rederick	m> 20	0678
	Sta Registr	_	JAN 13 2004 Security Signature	Sparle			

		•			22perFHG	of Ma 328 2/	aryland 9/04 E	J Cer	tificate of	Death	ia Ment		ene 2	104	03610
	Physicia	an	1. Decedent's Name Upshur	(First, Middle Henry							М	ate of Death Ionth	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (//			number)	-		4b. City, Town, o	r Location of D	J <i>A</i> Death	711/	0.7 2 4c. County	0 04 of Death	7:53 a
	Examin		Berlin N		Home				Berlin					ceste	
	Funeral Director		5. Social Security N 220–26–32	69	6. Sex 1 → M 2 □ I		e (In yrs. Ia 75	st birthday) Yrs.	If Under 1 Year Months Days	Hours I	Min. 8. D. Min. Jur	ate of Birth fonth, Day, 1e 16,	<sup>Year)</sup> 1928		ace (State or Foreign try) MD
land	Mo TE		Usual Residence of 10a. State	10b. County			10c. City,	Town or Lo	cation					10	0d. Inside City Limits
э Магу	a-f sh illied	ctor	MD	Worc	ester		Be	rlin							1X Yes 2 ☐ No
ith the	or 28	Funeral Director	10e. Street and Nur						10f. Zip Code			10	og. Citizen of V		try?
eath v	18 23e	eral	10413 Har	rison l		ecedent	Ever in U.S	i. 13. \	21811	lispanic Origin	? (Specify Y	es or No-	U.:	S . e - Americ	an Indian,
SHUR 1 <b>215-0036</b> within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Modical Examinar count be notified at	Ď	1 XNever Marr		ned 1 TY	Forces? es 2 A Give or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, F Specify:	Puèrto Rican	, etc.)		ck, White, o	
HUR 215-0 Pin 72 Po	n "natura Madical E	Be Completed	(Spec	cify only highe	t's Education st grade complet	ed) je (1-4or :	5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	f working	1	16b. Kind of Bu	usiness/Ind	dustry
UPS d 213	al Hygiene other that vent, Inc.	Сош	8						Waterm		Nome /Fire	A Adiadallo A		hing	
and find	ed off	) Be	17. Father's Name Upshur H								Britt		Maiden Suman m	те)	
IRY aryl	and Mental is marked o	2	19a. Informant's N					19b. Mailir	ng Address (Street					State, Zip	Code)
HEN and 2	Health a		Patsy Bo	wen/ni	ece				3 Harris		The State St				
HENRY UPSHUR Baltimore, Maryland 21215-0036	Department of He Important: If Iten any injury or oth once.		20a. Method of Dis 1X Burial 2 • 4 □ Donation	Cremation	3 □Removal fr	om State			sition (Name of natory or other places  S Cemete		Date 12/200		ection - Berlin	•	
Balt Permit.	Departi Importa any inj		21. Signature of Fi	ner Service	Livensee			16 16	Name and Addrewis N Wats 18 West Rd	on Funer Salisbu	al Home ry,Md 2	21801		_	
E penned	Medical xaminer street is as the buriat-transit	Examiner	234. Part1. Enter to shock, or heat immediate Cause disease or condition resulting in death)  Sequentially list continues. Enter Under Cause. Enter Under Cause (Disease or that initiated event resulting in death)	(Final on onditions, onditions, one of the original o	b. Oue	tiz o to (or as	d the death. ne. a consequence a consequence	ence of):	er the mode of dyli	ng, such as ca	rdiac or resp	land area	Desce.		Approximate Interval Between Onset and Death
of Vital Records, P.O. Box 68760,	ed by the attending physici detached for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	? months? □ No	1⊡Li 4□P	ve birth	of pregnar 2  Fetal t time of de	death 3	Ectopic pregnanc Other (specify)	у			23d. Da	te of delive	ory Day Year
rds, F	been signed should be de	d by P	Part II. Other signi	ficant conditi	ons contributing	to death b	out not resu	Iting in the u	nderlying cause give	ven in Part I.	<u>a</u> '				e cause of death? ably 4 Dunknown
Vital Record	ite has bee	omplet	Coron	any l	Luxer to	Tuni	R.	alel	ines	Diese		24a. Was ar autopsy perform	y ned?	Were autop prior to cor death? 1  Yes	psy findings available inpletion of cause of
/ital	is certificate ha director, page	Be	25. Was case refe examiner?	rred to medica					Out		f Death (Che	eck only one	e)		
Physi of	this cral dire	.T	1 Yes 27					ER/Outpatier 28b. Time o	IL 3 DOA				nce 6 Oth		1)
$\frac{1}{2}$ (vision	uth. :: After th e funeral	ation	1 ⊠Natural 2 □ Accident	5 🔲 Pendi	ng (i	ate of Inju Month, Da	ay Year)	Injury	M 1	rk? ]Yes 2⊟No					
Divis	s after death. Il Director: A Id in by the fu	Certification;	3 🗍 Suicide 4 🔲 Homicide	6 Could deten	ningd 400. F	lace of In uilding, e	jury - At hor tc. (Specify	me, farm, sti	reet, factory, office		28f. L	ocation (Str City or Town	reet and Numb , State)	er or Rura	l Route Number,
Hospit	within 24 hours after To the Funeral Dire completely filled in b	edical (	29a. Certifier (Check only one)	1⊠ Certifyi 2  Medice	Examiner: On the	the best he basis of manner st	of examinati	vledge, deat ion and/or in	h occurred at the ti vestigation, in my	me, date and popinion, death	place, and d occurred at	ue to the ca the time, da	use(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
٥	withir To th	Me	29b. Signature and	d title of certific	Ta 13	elle.		Za. 7	29c. Licens	se number	5^		9d. Date signe		
200	Q	-	30. Name and add				_			DR	SALI				
	Sta Registi		31. Date filed (Mod	nth, Day, Year			rar's Signat		Spar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 03611 2, Date of Death 1. Decedent's Name (First, Middle, Last) January 17, 2004 **Physician** 1900 Richard Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Clinton Southern Maryland Hospital Months Days Hours December 6, 1938 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 65 220-34-3926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at YE Yes 2 No Maryland Prince Georges Upper Marlboro Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20772 16601 Candy Hill Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1961

1 Yes 2 No
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Galloway Josephine Johnson Maurice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16601 Candy Hill Rd Upper Marlboro, Maryland 20772 Lynell Matthews/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 1/24/04 Resurrection Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Adams Funeral Home P.A. Aquasco, Maryland Udessa MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, church, Lichard 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 1 Yes 2 2 No 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be spital: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Dite of Injury
(Month, Day Year)
28b. Time of Injury
Injury
28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 0 27. Manner of Death

1 ANatural

2 Accident 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number \$ 009923 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nomas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDUNF MD 20601 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JAN 2 Registrar

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 4 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Day 04/AM **Physician** Walter Franklin Jones, Jr. anvaru 2004 /Medical 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Mercy Hospital Baltimore 8. Data of Birth (Month, Day, Yaar) If Undar 24 Hrs. If Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Hours 1**□**√M 2□ F Days 216-36-7346 Director 65 Mar. 27, 1938 Maryland Usual Residence of Decedent 10c. City, Town or Locetion 10d. Inside City Limits 10a Stata 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural", or items 23s or 23s-f show any injury or other traumetic event, the Medical Examiner must be notified at once. 1 ☐ Yas 2 📆 No Directo Calvert Maryland Huntingtown 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 2079 Plum Point Road 20639 USA Completed by Funeral 12. Was Dacadant Evar in U,S. Armad Forces? 1 ☐ Yas 2 ऒ No If Yas, Give Yaar or Datas: 14. Race - Amarican Indian, Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status Black, Whita, etc. 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Spacify: Black $\cup \mathcal{OD}_{\mathcal{CS}} \quad \mathcal{MAITC}$ Baltimore, Marylard 21215-0020 Specify: 3 X Widowad 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Excavating Co. Collega (1-4or 5+) 12 Superintendent 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Walter Franklin Jones, Sr. S. 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Joyce E. Rice/Sister P.O. Box 193 Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) Young's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/04 Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signatura of Funeral Sarvice Licensa-1451 Dares Beach Road 4. Prince Frederick, MD 20678 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiralory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Betwaen Onset and Death Physician Immediate Cause (Final disaasa or condition rasulting in daath) /Medical un Examiner Due to (or as a consequence of): Examiner for use es the bunel-transit Hospital or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Causa (Diseasa or injury that initiated evants resulting in death) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Dua to (or as a consequence of): within 24 hours efter death. To the Funeral Director: After this certificete hes been signed by the completely filled in by the funeral director, page 2 should be deteched? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 ☐ No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performad? 1 ☐Yes 2 ☐ No 1 🗆 Yas Medical Certification: To Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) NOSPICE Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Yaar) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 5 ☐ Panding invastigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Straat and Numbar or Rural Route Numbar, City or Town, Stata) 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 16 Rev 6/95

State

2

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Nama and address of person who sumplated cause of daath (Item 23a) (Type, Print)

2003

Risebera

ST.

32. Ragistra s Signature

Paul

29c. Licansa numbai

40854

Baltimore

29d. Date signed (Month. Dav. Yaar)

2004

			1 - For State Registrar	State of Marylan		artment of H			ene g. No. 2001	03613
	Physici		1. Decedent's Name (First, Middle, Last) Freida	Elizabeth		ones		2. Date of Death Month January	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s Calvert Memoria			4b. City, Town, or Prince	Freder	ick	4c. County of Deat	rt
	Funeral Director		5. Social Security Number  214-34-4191  Usual Residence of Decedent	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 0ct.12	9. Birt , 1919 Mai	hplace (State or Foreign ountry) ryland
	e Maryland Sa-f show	ctor	10a. State 10b. County  Maryland Calve		ty, Town or Lo	cation Huntir	ngtown			10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	th with th 23a or 24 ust be no	al Director	10e. Street and Number 4470 Harvest	Lane		10f. Zip Code 206	39	10	g. Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other treumatic event, it is Madical Examinate rust be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	<ul><li>12. Was Decedent Ever in U Armed Forces?</li><li>1 ☐ Yes ZY No If Yes, Give Year or Dates:</li></ul>		Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 2 ☒No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: B 1 a	e, etc.
Maryland 21215-0036	within 72 ho ane. then "natur e M. Jical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	tent's Usual Occupa kind of work done o DO NOT use retired, Cook	luring most of wor	rking	6b. Kind of Business/	·
and 2	Ibe filed ntal Hygie ed other event, II	Be	17. Father's Name (First, Middle, Last)  Marion	Holland		COOK	18. Mother's Nar	ne (First, Middle, M	Restaura Haiden Sumame) Scott	int
aryk	2 should and Mer Is mark eumatic	ဥ	19a. Informant's Name/Relationship (Type	oe, Print)			ınd Number or Au	ıral Route Number,	City or Town, State, 2	Zip Code)
nore, M	ages 1 and 3 of Office 1 and 3 of Health 27 or other tr		Gaines Jones/So  20a. Method of Disposition  1 Deurial 2 Cremation 3 Re	emoval from State	Place of Dispo cemetery, crem	Box 71 sition (Name of natory or other place	9)	Date 2	0c. Location - City or	
Baltimore,	permit. Pa Departmen Important any injury once.		21. Signature of Funeral Service License  Headure Co.		22	. Name and Addres	s of Facility S	ewell Fu	untingto ineral Ho ince Fre	wn, MD ome ed.,MD 2067
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	cations that caused the deat e cause on each line.  Due to (or as a consequence of the co	Asy juence of):	hy Hhmi	4.	or respiratory arres		Approximate Interval Batween Onset and Death IO minutes More trap
ox 68760,	eath certificate be executed attending physician and for use as the burial-transit	/Medical Examiner	resulting in death) Last	Due to (or as a conseq	ancy				23d. Date of del	ivery
P.O. Box	that the death cer ed by the attendir detached for use	hysiciar	in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
ords, P	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	ted by P	Part II. Dther significant conditions con Encl-Stage Re	tributing to death but not res	ulting in the ur	Hemock	in in Part I.		acco use contribute to	the cause of death?
al Reco	: The law r cate has be page 2 sh	Completed by Physician/Me	typestensive	ery clisea that di	sease	seps	1°S -	24a. Was an autopsy perform	ed?   death?	topsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires tha within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	ation; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	<sup>IT:</sup> 4□ Nursing H	one 5 Residen  28d. Describe how	nce 6 □Other (Spec	sify)
Divis	the Hospitel or Attending nin 24 hours after death. the Funeral Director: Afte npletely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	(y)			City or Town,		
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medice! Examin	ician: To the best of my knoner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	estigation, in my op	inion, death occu	rred at the time, dat	te and place, and due	to the cause(s)
	To T	2	29b. Signature and title of certifier	- c - h	war.	29c. License	5065		d. Date signed (Month	2004
_	5		30. Name and address of person who cor 5851 - De al	e churchy	on	Print) GYF Road.	Peals	SURAI MD.	20751	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1	32. Registra Signa	ature	Sparks			-7-	

	72570	Ī.	1 - For State Registrar	State of Maryla		artment of Health a tificate of Death		ene 2004	03614				
			1. Decedent's Name (First, Middle, Las	_			2. Date of Death Month		3. Time of Death				
	Physicia /Medic				ones	45 City Taylor and continue of	January						
	Examin	er	4a. Facility Name (If not institution, give 6200 9th Str			4b. City, Town, or Location of Chesapeake		Calve					
	Funeral Director		5. Social Security Number 6. Security Number 17-46-7299	7. Age ( <i>In yr</i>	rs. last birthday) 2 Yrs.	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Min. July 24	,1951 Mar	hplace (State or Foreign unity) yland				
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation			10d. Inside City Limits				
	Maryla	ğ	Maryland Calv	ert	Cl	nesapeake Be	ach		1 ☐ Yes 2 📶 No				
	th with the 23a or 28a ist be noti	Funeral Directo	10e. Street and Number 6200 9th Str	eet		10f. Zip Code 20732	10	0g. Citizen of What Co USA	ountry?				
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural, or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.				
5-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occupation kind of work done during most DO NDT use retired)	of working	16b. Kind of Business/	Industry				
21215-0036	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		alth Aide		Nursing	Center				
	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mer	Be C	17. Father's Name (First, Middle, Last)	Red	- d	18. Mother	r's Name (First, Middle, N	Meiden Sumame) Rice					
Maryland	J Ment J Ment narked natic e	ဥ	Aaron  19a. Informant's Name/Relationship (7)			ng Address (Street and Number			Zin Code)				
	and 2 st ealth and n 27 is r		George Jones/H				untingtown						
Baltimore,	Pages 1 and 2 nent of Health snt: if item 27 i		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 1 □ Contain 5 □ Other (Specification 1)	Removal from State	n. Place of Dispo cemetery, crei	esition (Name of natory or other place)  eJones Cem	1/28/2004	20c. Location - City or Chesapea	Town, State ke Bch., MD				
Prince Frederick, MD 20078													
			shock, or heart failure. List only			Approximate Interval Between Onset and Death							
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons		~ 06	Colon		2				
	Examiner	Ш	One and the first and distance	busing with	C	a of Melasi	2505		2 years				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events	Due to (or as a cons	sequence of):				v				
_`	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):								
58760,	ate be nysicia he bur	ical		d									
Box 68	death certifics e attending pt id for use as t	0	IF FEMALE: 23b. Was decedent of egnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy		23d. Date of del	ivery Day Year				
P.O. B	that the deal ed by the att detached fo	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown		Other (specify)							
	w requires that the death certifi been signed by the attending should be detached for use as		Part II. Other significent conditions of	ontributing to death but not	resulting in the u	nderlying cause given in Part I.	23e. Did tob	sacco use contribute to	robably 4 Unknown				
I Records,	The larate has	Completed					24a. Was ar autops perforn 1  Yes 2	y prior to death?	utopsy findings available completion of cause of				
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	- Carrie	Othor	of Death (Check only one		a(4.)				
of	<b>a</b> a a	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2  28a. Date of Injury (Month, Day Year	28b. Time o	IL 30 DOX   40 NO		nce 6 Other (Spe w injury occurred	ciry)				
sion	Attending r death. ector: After by the fune	catio	1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	n		M 1   Yes 2   I							
Division	tel or Att rs after d el Direct ed in by	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, office	City or Town	reet and Number or Ri , State)	urai Houte Number,				
	To the Hospitel or Attendin, within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To t To t com	Σ	29b. Signature and title of certifier	Sterial of	Phys -	29c. License number	<u> </u>	9d. Date signed (Mont	O T				
	4		30. Name and address of person who	completed cause of death (	Item 23a) (Type,	Prince	Frederick	MD 2	0678				
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 2 3	32, Registrar's Si	gnature	Carl )							
			CAN A J	LUUY   RESERVED	AS" AS	July and the same of the same							

			1 - For State Registrar	State of M	laryland	-	artment of tificate of		and Mo		iene2004	03615
	Physici	20	1. Decedent's Name (First, Middle, L	ast)						2. Date of Deat Month	h Day Year	3. Time of Death
z	/Medic		Robert	Fran		K	inter			Januar	y 16 2004	8:15 a M
	Examin	er	4e. Fecility Name (If not institution, gr	ve street and number	)		4b. City, Town,	1800	of Death		4c. County of Deet	1
			12030 Century Ma 5. Social Security Number 6.		ge (In yrs. la	et hirthday)	Dun If Under 1 Yea	kirk r   If Under:	24 Hrs.	8. Date of Birth	Calvert	palace (State or Foreign
	Funeral Director			1⊠M 2□F	86	Yrs.	Months Day		Min.	Month, Day, Dec 15,	1917 Pen	nplace (State or Foreign untry) nsylvania
			159-16-1697 Usual Residence of Decedent		- 00					Dec 13,	1717   FEII	iisyivaiiia
	nylan show	_	10a. State 10b. County		10c. City.	, Town or Lo						10d. Inside City Limits
	8e-f s	Director		Calvert			_	Dunkir	k			1 ☐ Yes 2 ☐ No
	or 2	ä	10e. Street and Number				10f. Zip Code			1-	0g. Citizen of What Co	untry?
	s 230	rai	12030 Century Ma	nor Drive	· Ever in III 6	2 112 1		20754	sin2 (Coo	aitu Van ar Na	USA 14. Race - Ame	ican Indian
	Herr d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces	?	3.	Was Decedent of f Yes, specify Cu	ban, Mexican	n, Puerto F	Rican, etc.)	Black, White	
9	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		53	1 ☐ Yes 2 🂢 N	Specify:			Specify: wh	ite
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, I're Medical Examinar mant be multiped at	Completed	15. Decedent's I	Education		16a. Deced	dent's Usual Occi	upation	t of workin	ia l	16b. Kind of Business/l	ndustry
2121	of thin	dr jd	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retir	red)			71	
2	filed with Hygiene. Sther ther		17. Father's Name (First, Middle, Las	2		COMM	ercial d	T			G.E. medic	al systems
anc	be de la	Be	Peter Watsor		or.			Mary		Olive	Cost	
Maryland	2 should be and Mental Is marked o	၉	19a. Informant's Name/Relationship			19b. Mailir	a Address (Stree				City or Town, State, Z	in Code)
S	C1 00 05		Johanna T. Kinte								nkirk, MD	20754
<u>6</u>	s 1 and if Health item 27 other tr		20a. Method of Disposition		20b. Pla		sition (Name of natory or other pi				20c. Location - City or	
altimore,	Pages nent of I ant: If its ary or o		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec		, ,			1	01/20	0/2004	Prince Fre	derick, MD
a	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	ensee of	77.00		. Name and Add			Year of		
<u> </u>	82 5 8		William	K. tru						<u> </u>	, Owings,	MD 20736
p.	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List ont Immediate Cause (Final disease or condition	y one cause on each	d the death. line.		er the mode of dy	ing, such as	cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):	1.4	D 1				
		-	Sequentially list conditions, if any, leading to immediate	b. Chru	s a conseque	Obst	ructive	Jul	mor	rary 1	disease	years
	betr I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury							1		
,	execting and ital-tra	Еха	that initiated events resulting in death) Last	Due to (or a	s a consequ	ence of):						
760	ate be executed hysician and the burial-transit	icai	(	d								
89	certificate be executed iding physician and ise as the burial-transit		IF FEMALE:				<del>*************************************</del>					
Вох	death certific e attending p od for use as l	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom- 1 ☐ Live birth			Ectopic pregnan	су			23d. Date of delif	very Day Year
0.	0 0	/sici	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of de	ath 5□	Other (specify)				Monter	Day 16al
a.	The law requires that the te has been signed by the bage 2 should be deteched.		Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying cause o	iven in Part I		23e. Did tob	acco use contribute to	the cause of death?
ecords,	uires that signed b	d by	Arteriosclerota	Cerreliove		_				1 ☐ Ye	s 2 <b>X</b> No 3□Pro	bably 4 Dunknown
Ö	w require been si should t	ete	Arrhythmias -	Atrial F	ibrilla	Hon				24a. Was ar	24h Were aut	opsy findings available
Ř	he las e has age 2	Completed		1 Cell Bi			3			autopsy	prior to c death?	ompletion of cause of
Vital		0	25. Was case referred o medical	1 CELL ISI	waae	r Ca	rememo		of Death	1 ☐ Yes 2		2 □ No
	or Attanding Physician: The law itter death. Director: After this certificate has b in by the funeral director, page 2 s	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	ient 2 🗆 E	R/Outpatien	t 3 DOA	ther	rsing Hom	-0	nce 6 ☐Other (Spec	ify)
Division of	ding Ph th. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	28c. Inj W	ury at ork?	21	8d. Describe ho	w injury occurred	
Sio	tendii Jeath. Tor: A the fu	catic	2 ☐ Accident investigati	on				∐Yes 2 🗀 1	No			
$\frac{2}{5}$	I or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not determine	A 200. Place of it	njury - Al hor itc. (Specify)	me, farm, str	eel, factory, office	9	28	8f. Location (Str City or Town	reet and Number or Ru , State)	al Route Number,
	pitel ours a erel [		29a. Certifier 1 Certifying F	hysician: To the hor	t of my know	uladaa dassi	nonured at the	time data sa	d place =:	nd dua to the	use(s) and manner as	rtated
	To the Hospitel within 24 hours a To the Funeral completely filled	Medicai	(Check only one)	minar: On the basis and manner s	of examinati	on and/or in	estigation, in my	opinion, deal	th occurre	d at the time, da	use(s) and manner as ite and place, and due	to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier					se number			d. Date signed (Month	
			Genold	P. Sten	er w	M	1	1724	5	Md. J	annary 1	6, 2004
			30. Name and address of person who			23a) (Type,	Print)		1 00	, ,		
	10+1			Rner M		CAlve	nt-ARU	inde 1	Thedi	CAL G	Tannary I	ngs MD
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2. 0. 2004	32. Regist	trar's Signati	ure					,	

ORIGINAL

			1 - For State Registrar	State of	Marylan		artmen rtificate				ental Hy	giene Reg. No.	200	4 03	3616
	D. (1.1		1. Decedent's Name (First, Middle, Las	t)							2. Date of De	ath		3. Time	e of Death
	Physicia /Medic		Steven Andrew Kep	ich			,				Januar	ry 17	2004	10:	04 AM
}	Examin		4a. Facility Name (If not institution, give						Location o	of Death			County of De		~ Co
			Southern Maryland 5. Social Security Number 6. Se		L Cente		Clint		If Under	24 Hrs.	8. Date of Bir		ince C	rthplace (Sta	
H	Funeral Director		219-64-5571	FORM OF F	50	Yrs.	Months	Days	Hours	Min	Sept . S	у, <sub>Үөаг)</sub> 19	053 New	Jerse	ey
	and		Usuat Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. tnside	City Limits
	be filed within 72 hours after death with the Maryland at Hygiene. Hygiene dither than "natural", or itema 23a or 28a-f ehow other than "natural", or itema 23a or 28a-f ehow event. If a Madical Examinar most be notified at	tor	MD Prince Ge	orge's (	Col Ur	oper Ma	arlboi	ro						1 🗆 Y	es 2 No
	th the	Funeral Director	10e. Street and Number	0150 0			10f. Zip						zen of What (	Country?	
	ath w	rai	6506 Dublin Place					772					S.A.		
	er de	nne	11. Marital Status	12. Was Deced	es?	S. 13.	Was Deced If Yes, spec	lent of His	spanic Orig n, Mexican	gin? (Spe 1, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - An Black, Wh		,
36	urs aft	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2	2 X No	Specify:				Specify: V	hite	
21215-0036	72 hou	Be Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Usua	d Occupa	ition	t of workin	10	16b. Ki	nd of Busines	s/Industry	
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of wor DO NOT us			e di Workii	y .		7.6		,
	filed w Hygier Ather th	S	12. Father's Name (First, Middle, Last)			HVAC '	rechn:	icia		rda Nama	(First, Middle,		eral Go	vernme	ent
Maryland	ouid be f Mental F arked of atic evel	To Be	Andrew Keppich, S	od.							e Piech		,		
	2 should be and Menta is marked aumatic ev	ř.	19a. Informant's Name/Relationship (7			19b. Maitir	ng Address	(Street a			Route Numbe			Zip Code)	
	2 = 2 = 2		Margarete R. Kepic	h (Moth					100000	Upp	er Marl	lboro	, MD 2	20772	
altimore,	ges 1 ar of Hea of item or other		20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from S		lace of Dispo emetery, crem					ry 22,		cation - City o		
Ē	trent of tant: If it it it or o		*4 Donation 5 □ Other (Specify		- Sou	thern l	Mem. (	Gard	ens	2004	Uhan oraș		rirk, M		
Ba	permit. Pages Department of I Important: If its any injury or o		21. Signature of June Service Cices								Funera and Blv				
	age All		23a. Part1. Enter the disease, or emp shock, or heart failure. List only	lications that can one cause on ea	used the death ch line.	h. Do not ent	er the mode	e of dying	such as	cardiac or	respiratory ai	rrest,		Approxin Interval I Onset ar	Between
X.	Physician (Madical		tmmediate Cause (Final disease or condition resulting in death)	a Aw	re Mu	40 care	did	In	torc	tion	l			Oriset al	IG Death
5	<ul><li>/Medical Examiner</li></ul>			C.	r as a conseq	dence of):	d	Dec							
	79	er	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consed	uence of):	ry	Dr.2	tesi						
	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	· Metas	atic	Lune	CA	NCE	R						
/60,	ate be executed hysician and the burial-transit		resulting in death) Last	,	r as a consequ	,	. 1	i _							
687	death certificate be executed e attending physician and id for use as the burial-transit	dicai	•	d. INT	RA CE	REBRI	AL T	tem	mor	HH	3 C	7.	- 1000		
ROX	leath certific attending pl	N/M€	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outco								2	3d. Date of de	livery	
		sicla	in the past 12 months? 1 □ Yes 2 □ No		th 2 □ Fetal nt at time of di		Ectopic pre Other (spe						Month	Day	Year
J.	at the de d by the a etached f	Physician/Med	9 Unknown					_							
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions co		ith but not resi	ulting in the ur	nderlying ca	ausa give	n in Part I.				se contribute i		
Hecords,	w requ	iete									24a. Was			utopsy finding	
	sician: The law certilicate has l irector, page 2 s	Completed									autop		prior to death?	completion of	
VII	stan: artifica ctor, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	1  Yes (Check only o			3 2 140	
0	th is	၉	1 ☐ Yes 2 ☐ No	-19		ER/Outpatien			4 ( I\u)	-	e 5 Resid			ecify)	
	ling After une	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month)	Day Year)	28b. Time of Injury	28 М	Bc. Injury Work	at ? ′es 2 ⊡ N		8d. Describe h	10w intury	occurred		
DIVISION	at or Attending s after death. I Director: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	288. Place 0	f tnjury - At ho	ome, farm, str			63 2	-	8f. Location (S	Street and	l Number or P	ural Route N	umber,
S		Certification:	4 Homicide determined	building	, etc. (Specif)	()					City or Tox	vn, State)			·
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Phyons 2 Medical Exam	ysician: To the base iner: On the base and manne	is of examinat	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, at th occurre	nd due to the d d at the time, d	cause(s) date and	and manner a place, and du	s stated. e to the cause	e(s)
	To the within To the Comp	Me	29b. Signature and title of certifier					License					signed (Mon	-	
•			296. Signature and title of certifier				D	403	324			JAN	JARY 1	7,200	94
	5		30. Name and address person who of Terry A. Jodrie,	M.D. 750	of death (ttem )3 Surr	atts R	Print) load,	Clin	iton,	Mary	land 2	0735			
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2	0 2004	gistra s Signa	ture	Some	we s							
	Registr	ar	JAN &	V ZUU4	MARCHA	1 10	A Day	SEL.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Michael Konik lorn 11:55 AM Junuary 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore, Maryland University of Maryland Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov 26, 1 None 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 197 20 8901 74 Pennsylvania Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo MD Carroll Sykesville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4305 Coolidge Court 21784 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White "natural", r than "natur. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Cake Decorator Giant Food it of Health and Mental Hyg if item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Konik Sr. Mary Beloski ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bobby/Daughter 2088 Harvest Farm Road Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **I** Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Deportment of Important: If any njury or Mt. Macrina 1-20-2004 Uniontown, PA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Shens Collin 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myelogenous Leukemin 2 weeks /Medical Due to (or as a consequence of) Examiner Bacteremia week 5-cuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Respiratory Failure Due to or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 si 1 ☐ Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 世 15261 01/16/2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. Baltsmore 21201 31. Date filed (Month, Day, Year) 32. #egistrar's Signature State JAN 20 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 23, 2004 **Physician** Patrick Joseph Kelly 7.30 AM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2700 Stinnett Road Huntingtown Calvert County If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 1 ፟ M 2 ☐ F 8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Larch 3, 1938 Washington, DC if Under 1 Year 7. Age (In vrs. lest birthdev) **Funeral** Months Days Yrs. Director 213-38-4155 65 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Calvert County Huntingtown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2700 Stinnett Road 20639 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours aftar or Department of Health end Mantal Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Experiment. XYes 2 □ No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☑ Widowed 4 Divorced White Year or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 RealEstate/Realtor Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Sadie Frances Hansbury Edward B. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2696 Stinnett Road, Huntingtown, MD 20639 Christopher B. Kelly (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jahr. 29. 1 Burial 2 □ Cremation 3 □ Removal from State 2004 Dunkirk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 21. Signature of Fund Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael 8125 Southern Maryland Blvd., Owings, ID 20736 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last Due to (or es a consequenca of) Physician/Medicai Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco uee contribute to the ceuee of death? 1 Nee 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 \ Homicide 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be assecuted within 42 hours either death.

To the Funeral Director After this cartificata has been signed by the ettending physician and completaly filled in by the funeral director, paga 2 should be datached for use as the bunkal-transit Division of Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0020

10+1

State

Registrar

(Check only one)

29b. Signature and title of certifier

clower 13 31. Date filed (Month, Day, Year)

8-2 32 Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Varkey Matthew, M.D.

29c. License number

145435

w.t.netoc.v

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Amend Item#19aper INF, Item#23aper PHYC828 2/9/04 EW Amend of Health and Mental Hygiene 2 0 0 4 03619 For AMEND#26 Per PHY. State of Maryta State Registrar 1/15/04 CMH AACO HEALTH DEPT. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jan. 2004 Elmer C. Knox 11:20 a<sup>M</sup> /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 153 M 2 □ F 65 218-34-0470 Director Mar. 11, 1938 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b County r than "natural", or items 23a or 28a-f ahow the Medical Ezand, ar must be notified at MD Anne Arundel Annapolis 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 969 Mt. Holly Drive 21401 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 56, 50 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married White 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates: 56-59 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Washington Suburban Elementary/Secondary (0-12) College (1-4or 5+) Crew Chief Sanitary Commission 12 it of Health and Mental Hyg If item 27 is marked other or other traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Emerson Knox Grace (Unavailable) ဥ 19a Informani's Name/Relationship (Type, Print) Nancy J Knox Knox/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 969 Mt. Holly Drive, Annapolis, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan. 15, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. MD Veterans Cemetery Crownsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Laura Part 1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) avvest **Physician** CIY Drac /Medical Due to (or as a consequence of) **Examiner** L&200 rato Sequentially list conditions, Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Exam EMPHYSEMA/COPD burial-tra Due to (or as a consequence of). Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year 0 in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at lime of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate 2 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pecidence 6 Other (Specify) ၉ 1 Yes 2 2 No 2 ER/Outpalient 3□ DOA o this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; sion Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. unerel Director: / 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide hin 24 hours aft the Funerel Di mptetely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 000 20030741 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Schmidlein, M.D. 844 Ritchie Hwy, Severna Park, MD 21146

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

JAN 1 5 2004

			for State Registrar		State of M	arylan	id / Dep $C\epsilon$	artment o <i>rtificate</i> d	f Health i of Death	and Me	ntal Hyg	giene2 (	004	03620
	Physici	an	1. Decedent's Name	(First, Middle, La.	st)					2	. Date of Dea Month		Year	3. Time of Death
	/Media	al			IARY ANI		LEAHY				anuar	y 22,	2004	2109 M
	Examir	er			estreet and number) eral Hosi		1	Ber1	n, or Location	of Death			nty of Death Ceste	ar.
	Funeral Director		5. Social Security No. 499-32-7	umber 6. S			last birthday Yrs.	If Under 1 Y		Min	Date of Birth (Month, Day – 14–3	Year)		place (State or Foreign
	pug *		Usual Residence of 10a, State	Decedent 10b. County		10c. Cit	y, Town or L	ocation					1	Od. Inside City Limits
	Maryli f sho	ō	MD	Worcest	er		ean F							1 ZYes 2 ☐ No
	r 28a	Director	10e. Street and Nun		,c.	00		10f. Zip Cod	le			10g. Citizen o	of What Cour	ntry?
	th wit	ai D	1212 (	Carrollt	on Lane			21	811				USA	
396	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Eran in an initial termolifical at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2 Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tes 2 King If Yes, Give Year or Dates:		.S. 13.	Was Decedent If Yes, specify ( 1 ☐ Yes 2/07			fy Yes or No- can, etc.)		ace - Americ lack, White,	etc.
ဂ္ဂ	72 hou	ted	/Cana	15. Decedent's Ed	lucation		16a. Dec	edent's Usual Oc s kind of work do	cupation	-		16b. Kind of	Business/In-	dustry
21215-0036	within and the within	Completed	Elementary/Secon	ify only highest gra ndary (0-12)	College (1-4or	5+)	life.	memake	tired)	st or working		Own H	OMA	
р Б	filed v Hygie othar t		1.2 17. Father's Name (	First, Middle, Last)			110	memaxe		er's Name (F		Maiden Suma		
Maryland	Jid be Jental rkad c	To Be	P. Lec	Luning	ſ				Ma	rgare	t Dal	ton	,	
<u>a</u>	2 should and Men is marka aumatic		19a. Informant's Na	me/Relationship (	Type, Print)		19b. Mail	ing Address (Str	eet and Numb	er or Rural R	Route Number	r, City or Tow	m, State, Zip	Code)
	1 and lealth Im 27 lher tr	1	William 20a. Method of Disp		ny Spo			Carro		Lane	-			
Baltimore,	permit. Pages 1 an Department of Heal Important: if itam 2 any injury or other once.		1 ⊠ Burial 2 Donation	Cremation 3 5 Other (Specify	Removal from State	C	emetery, cre	omatory or other of th	place)		-26	20c. Location Ocea		nes, Md.
Ball	permit Depar Impor any in		21. Signature of Fur	neral Service Licen	llik.			2. Name and Ad 111rich		•	ome	Berli	n, Mo	d.
	Medical Examined Appropriate be executed by physician and as the burial transit	edicai Examiner	snock, or hear Immediate Cause (I disease or condition resulting in death)  Sequentially list conif any, leading to in Cause (Disease or intan initiated events resulting in death) L	Final nations, mediate nations, injury	b. Due to (or as  Due to (or as  Due to (or as  Due to (or as	a consequal	uence of):	OCAKU	46 112	GRET I	ION .			Interval Between Onset and Death In In Epi ATE
.O. Box	ath cert trendin or use	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 I Yes 2 S Unknown	nonths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregna					Date of delive	ory Day Year
٥.	quires that the dei n signed by the a uld be detached f		Part II. Other signifi	cant conditions c	ontributing to death b	ut not resi	ulting in the t	undertying cause	given in Part I.					e cause of death?
Vital Records,	The law ate has b page 2 s	Completed							<del></del>		24a. Was a autops perform	ned?	. Were autor prior to con death? 1  Yes	osy findings available npletion of cause of 2 \sum No
Zita Zita	Physician: rthis certific ral director,	Be	25. Was case referrexaminer?	ed to medical	Hospital:						check only on	e)		
ō	Phys r this ral dir	٠ <u>.</u>	1 Manner of Death		1 ☐ Inpatie	tendrice and district or being	ER/Outpatie 28b. Time o	nt 3 DOA	Other: 4 ☐ Nu			ence 6 Ot		)
0	g age	ation	1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury		njuryat Vork? □Yes 2□I	Į.	. 2000.120110	W III qui y Cood		
Division of	Hospital or Attanding 24 hours after death. Funaral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At ho	ome, farm, st	reet, factory, offi	СӨ	28f.	Location (St. City or Town	reet and Num n, State)	ber or Rural	Route Number,
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1☐ Certifying Ph 29 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examinat	wledge, dear tion and/or in	h occurred at the vestigation, in m	time, date an y opinion, dea	d place, and th occurred a	due to the ca at the time, da	ause(s) and mate and place	nanner as sta , and due to	ated. the cause(s)
	To the within To the comp	ž	29b. Signature and t	title of certifier	(			29c. Lic	ense number		25	9d. Date sign	ed (Month, [	Day, Year)
)			Down	Ky C. 1	Pohimit	M.s	/	1	0629	41		1-2	4-09	L
٤	T 5		30. Name and address Do Ror		HOLZ WOZ	eath (Item	23a) (Type,	Print)	5	~	5.1.	4	1/2 3	
	Sta Registr		31. Date filed (Monti	h, Day, Year)	32. Registr	ar's Signal	ture	263	- NOW	211	JNUW	IVE, N	De di	86.3
	riegisti	-11	J	AIN & O CI	JUY JULIEUR	30 1	1 63	ASSEL						

MARY FINN LEHAY SS# 499-32-7262

		State of Maryland / Departi		-	ene	
			icate of Death		.No. 2004	03621
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		John Edward Latimer,Sr.		01	24 04	6:09a M
Examin		va. I domity it domestic for the state of th	b. City, Town, or Location of Death		4c. County of Death	
		Civista Medical Center	LaPlata Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Charles	lece (State or Foreign
Funeral Director			onths Days Hours Min.	(Month, Day, Y	(ear) 9. Birthp Coun	
Selection of the select		Usuel Residence of Decedent				
nylan show	<b>L.</b>	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 XYes 2 No
188-13	ecto	MD Charles La Pla	ta 10f. Zip Code	100	2. Citizen of What Coun	
death with the Maryland oma 23a or 28a-f show Ir must be rediffed at	Funeral Director	107 Morris Drive	20646	109	USA	,
death ma 23	era	11 Marital Status 12, Was Decedent Ever in U.S. 13, Was	s Decedent of Hispanic Origin? (Speas, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
or ite	Fur	1 ☐ Never Married 2 Married 1 ☐ Yes 2 2 No	Yes 2X No Specify:	rican, etc.)	Black, White,	hite
ural;	d by	3 Widowed 4 Divorced Year or Dates:		1.0		
n 72 h	Completed	(Specify only highest grade completed) (Give kind life, DO	t's Usual Occupation d of work done during most of worki NOT use retired)	ng	8b. Kind of Business/Ind	lustry
iene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) Buil	ding Inspector	r	Town	
y Idinica (12.15-0030) unicate filed within 72 hours after Mental Hygiene. srked other than "natural", or its after event, the Medical Examina	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
should by that Menta Menta Menta Menta Menta Menta Menta Menta marked umatic or	10 E	Evertt Burton Latimer		Joline		
2 sho			Address (Street and Number or Rura			
ire, INIGITY IGNITY Z. I.Z. 13-0030 s. 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Madical Examinal must be notified at		Emma Jean Latimer/Wife P.O.  20a. Method of Disposition 20b. Place of Disposition	Box 92, La P	lata, MD	20646 c. Location - City or To	wn, State
eges int of l		Z cemetery, cremato	Memorial 1/29	- 1		
Dallinore, permit. Peges 1 and Department of Heall important: If item 2 any injury or other once.		3/000/5	REHART ECHOLS			-
Depa impo		David C. Echole P	.O. BOX 567 .1	LA PLATA	A.MD 2064	6
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac of	or respiratory arres	t,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	ideal una	ictions		Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
*	5	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	U			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
rou, le be executed ysician and e burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):				
BOX 00/00, eath certificate be executed attending physician and for use as the burial-transit	Ilcal	d				
.C. BOX OS the death certificat y the attending phy ched for use as th	Physiclan/Medl	IF FEMALE: 23c. If yes, outcome of pregnancy			COL Date of delive	
DOX sath cer attendir for use	slan	in the past 12 months?	topic pregnancy ther (specify)		23d. Date of delive Month	Day Year
the dy the dy the dy	ysic	1 Yes 2 No 9 Unknown 9 Unknown	77			
	by Pi	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did toba	cco use contribute to the	/
ecords law requires as been sign	ted t	Hyperterisial		1 🗆 Yes	2 No 3 Prob	ably 4 🗷 Unknown
law ra la	Completed	d'abetes Pelliler		24a. Was an autopsy	prior to cor	psy findings available appletion of cause of
The The cate has page	Con			performe		21 No
OT VITAL MEC Physician: The law rihis certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?  Hospital:	Other	(Check only one)	ce 6 ☐Other (Specifi	
Phy Phy rald	): To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how		"
Attending at death. ector: After by the fune	atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
LIVISION  I or Attending after death. Director: Afte	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
Urs aft						
Hosp 24 hou Fune stely fi	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death or the basis of examination and/or investigant manner stated.	curred at the time, date and place, tigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)
DIVI:  To the Hospital or Ati within 24 hours after d  To the Funerel Direct completely filled in by	Mec	and City of another (	29c. License number	290	d. Date signed (Month,	Day, Year)
FSFO		B. havidher R.D	D-0056949		1/24/04	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Principle)			1 1	
196		Baig, Kamakshi, MD 6620 Crain H 31. Date filed (Month, Day, Year) 32. Red Strar's Signature	wy Suite 102	LaPlata	<u>, MD 2064</u>	6
Sta Regist		31. Date filed (Month, Day, Year)  JAN 2 8 2004  32. Refistrar's Signature	ede			

John Latimer,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30,2004 **Physician** James Henry McDowell Jan. 11:10p.m /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Moran Manor Westernport Allegany | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Dec . 17 , 1917 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 WV **Funeral** 1 M 2/2 F Yrs. 232-26-1431 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if Itam 27 is marked other train "natural", or items 22s ments any injury or other traumatic event in the analysis or other traumatic avent in the analysis page. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits WV Director Mineral Keyser 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 26726 U.S.A. 329 St. Cloud Street Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify. ě 3.⊟Widowed 4 □ Divorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Wholesale salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luke Parker McDowell Mary Elizabeth Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard K. Butler/POA Rt. 6, Box 6014, Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/02/04 Keyser, WV Potomac Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on fact line. Approximate Interval Between Onset and Death **Physician** acut myscardial Infantion Immediate Cause (Final disease or condition resulting in death) /Medical 4 houng Examiner Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the buriai-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Qknown millety Cetes 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2XINo 1 ☐ Yes 2 ☐ No B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes XXNo 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident s aftar death.

i Diractor: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C complately filled Hoapital 157 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
213 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21244 Jan31,2004 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Dr. Jesus H.

31. Date filed (Month, Day, Year)

Tan.,

FEB - 9 2004

32. Registrer's Signature

marke

M.D. Frostburg Plaza, Frostburg, Maryland 21532

		1 - For State Registrar	State of Maryland	d / Depa	artmer		ealth and	Mental Hyg			03623
Physic /Med Exami	ical	Dixie  Aa. Fecility Name (# not institution, give state)	Irma Mon	can			ocation of Dea	2. Date of Dea Month January	13	2004 County of Death	
Funeral Director		3220 Twin Oak Lane 5. Social Security Number 577–34–0079  Usual Residence of Decedent	7. Age (in yrs. ia	ast birthday) Yrs.		r 1 Year	gtown If Under 24 Hrs Hours Min		, Year)		ct oplece (State or Foreign ontry) oryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Exacultational the incities at once.	To Be Completed by Funeral Director	10a. State 10b. County  MD Calvert  10e. Street and Number  3220 Twin Oak Lane  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edur (Specify only highest grade (Specify) and highest grade (Specify)  12. Signature of Funeral Service License (Specify)	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes Signo M Year or Dates: Cation 10 completed) College (1-4or 5+)  Y Trathen De, Print) granddaughter emoval from State So.	16a. Decec (Give life. I 19b. Mailir 383 ace of Dispo metery, crem Memon	Harman Ha	al Occupation done of the control of	panic Origin? (5, Mexican, Puer Specify:  ion  18. Mother's Na  Robert  North  ens: 01-1  of Facility  eral Hol	Specify Yes or No- to Rican, etc.)  Trking  me (First, Middle,  Jess  ural Route Number  Beach, M  Date  7-2004	OW   USA  14. Race - Amer Black, White Specify: What of Business/line with home Surname)  Lovar Town, State, Zir 2071 4 cation - City or Talkirk, Manual M	nican Indian, , etc.  hite  ndustry   procede)  Town, State	
w requires that the death certificate be executed  we signed by the attending physician and should be detached for use as the burial-transit	Icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	you	de of dying,	9/7	correspiratory arr	10-	Disc	Approximate Interval Between Onset and Death
The Court, F.C. BOX 600 In The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 25 No 9 Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3	Ectopic p Other (s	regnancy oecify)			2	3d. Date of deliv	rery Day Year
wrequires that I been signed by should be deta	b	Part II. Other significant conditions con	tributing to death but not resul	ting in the ur	nderlying	cause giver	in Part I.		acco us		the cause of death?
ician: The law certificate has bector, page 2 s	e Completed	25. Was case referred to medical					26. Place of De	24a. Was a autops perform  1 Yes 2	ned?	24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
ng Physi fler this o	Certification: To B	27. Manner of Death  Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)  28e. Place of Injury - At hon	28b. Time of Injury	м	Other 28c. Injury a Work?	4 🗌 Nursing H	28d. Describe ho	ow injury	occurred  Number or Run	fy) a.l Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical Certi	29a. Certifier Certifying Phys	building, etc. (Specify)  ician: To the best of my know ter: On the basis of examination and manner stated.	ledge, death	Derruggo (	at the time	, date and place	City or Town	n, State)	and manner as s	stated.
To the within To the comple	Med	29b. Signature and title of certifige		2201/7		c. License	3717		1	signed (Month,	261
St Regist	ate trar	30, Name and address of person who co Jonethun Lowend 31. Date filed (Month, Day, Year) JAN 1		HOSPI	tul	Kou	Ste	310, TRIM	ce I	rederick	M) 20678

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 03624 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Physician Edith M. Moore 20, 1:15PM January 2004 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Somerford Place Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral**  Birthplece (State or Foreign Country) Hours Months Days 1 □ M 2 🛣 F Yrs Director 78 194-14-4812 May 8, 1925 Pennsylvania Usuel Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hygiena. Important: If itam 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Exemple. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3734 Ligon Road 21042 USA Funerai 11 Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administrative Assistant College 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Dean Matchett Olive Irene Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Karol Schwarzenberg/ daughter 3734 Ligon Road Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 22, 2004 Baltimore, Maryland 21. Signature of Funeral Service License Coing Home Cremation Service P.O. Box 784 Deve 0 No MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Alzheimer's Disease Examiner Due to (or as e consequence of) Examine ng physician and as the bunal-transit The law raquiras that tha daath certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence of): edicai Due to (or as a consequence of) attending I Physician/M nse n signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probabiy 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? peen s 1 Tes 2X No 1 ☐ Yes 2 ☐ No diractor, 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Assisted 9 1 ☐ Yes 2 💢 No Other: 1 🗆 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 XNaturel 5 Pending death. investigation 1 ☐ Yes 2 ☐ No i Director: A od in by tha f 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27394 January 21, 2004 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 0

State Registrar

James P. Richardson,

IAN 21

31. Date filed (Month, Day, Year)

32. Resistrer's Signature

MD

2004

**ORIGINAL** 

3333 N. Calvert Street Suite 325 Baltimore, MD 21218

Division of Vital Records, P.O. Box 68760.

		•	1 - For State Registrar	State of Ma		epartm		lealth a		ental Hygi	ene Z	2004	03	625
	Physici /Medic		Decedent's Name (First, Middle, La     James Ma	tthew Mal	loy					2. Date of Death Month January	Day	$20\overset{ ext{\scriptsize Year}}{2004}$	3. Time of t	Death ${ m P}^{ m M}$
	Examir		4a. Facility Name (If not institution, given Charlotte Hall Vo. 5. Social Security Number 6.5	eterans Ce	nter e (In yrs. last birt	(	city, Town, or Charlo		all	8. Date of Birth	St	Mary 9. Birtho	S place (State or	Foreign
	Funeral Director		579-14-0484 Usual Residence of Decedent	<b>№</b> М 2□ F	82	Yrs. Mon	ths Days	Hours	Min.	8. Date of Birth (Month, Day 1971 27	1921		iington	, DC
	death with the Maryland ims 23a or 28a-f show f must be notified at	Director	MD Cal	vert	Princ	e Fre	derick Zip Code			10	na Citizen	of What Cour	1 ☐ Yes	
	death with ms 23a or	Funeral Dir	1800 Hallowing	12. Was Decedent			206		gin? (Spec	cify Yes or No-	14. 1	USA Race - Americ	can Indian,	
3036	hours after of tural, or Item		1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	1944 <b>–</b> 45		specify Cuba s 2⊠ No	Specify:	, Puerto F	lican, etc.)		Black, White, ecity: Wh	etc. nite	
21215-0036	be filed within 72 hours after death with the Marylan tat Hygtiene, od other than "natural", or flems 23a or 28a-f show of other than "natural", or flems 29a or 28a-f showent, the Medical Exame avent, the Medical Exame har nust be notified at	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		i+)	(Give kind o life. DO NO	Jsual Occupa f work done o T use retired Carrie:	during most ()	of workin	g		f Business/In ostal S	<sub>dustry</sub> Service	:
Maryland 2	should be filed nd Mental Hyg marked other imatic event,	To Be C	17. Father's Name (First, Middle, Last  James Thomas	Malloy					r's Name ara	(First, Middle, N			Sand	
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship  Jean Brown (daug  20a. Method of Disposition		18	00 Ha	lowing	g Pt.	Road	Route Number.	e Fre		k, MD	2067
Baltimore,	t. Page rtment o rtant: If njury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	(y)	20b. Place of cemeter,	remato	ory	1	Jan 2 2004 Lee	11	linto	on, MD		
Ba	permi Depa Impo any ii		Gary J  23a. Part 1. Enter the disease, or con shock, or heart failure. List only	<b>C</b> off	the death. Do n	8123	South	nern M	Maryl	and Blv	d Ow		,	36
/60,	Physician /Medical Examiner parising and prize transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of a consequence of a consequence of	/ E	MBC						Onset and D	eath
O. Box 687	ath certificate ittending physor use as the	Physiclan/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ic pregnancy (specify)				23d.	Date of delive	,	<b>Bar</b>
ď	quires that the de n signed by the a uld be detached f	þ	Part II. Dther significant conditions  DEMONTIA, Pa	-	ut not resulting in		-		5		acco use o		ne cause of de	
il Records,		Completed	ABOVE PHE KNEE	ATION G	mone				E	24a. Was an autopsy perform		prior to co death?	psy findings a mpletion of cal	vailable use of
of Vital	Physician: The this certificate at director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		nt 2 ER/Out		DOA Othe	Fr: 4 Nur	rsing Hom	(Check only one e 5 ☐ Reside	nce 6 🗀		y)	
Division	Attanding Physician: Ir death. ector: After this certification by the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	y Ye <i>ar)</i> Ir ury - At home, far	njury M	_	yat ⟨? Yes 2 □ N	No	8d. Describe how			tl Route Numb	er,
ā	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	cal Certi	29a. Certifier 1 Cartifying P	building, et hysician: To the best miner: On the basis o	of my knowledge	, death occu	red at the tim	ne, date and	d place, ar	City or Town,	use(s) and	manner as s	lated.	
	To the H within 24 To the F complete	Medical	29b Signature and title of certifier	and manner sta	ated.		29c. License		3			ned (Month,		
2	+   Sta	ete.	30. Name and address of person who FUCTON UKA 31. Date filed (Month, Day, Year)	34m, ULI	eath (Item 23a) (	Type, Print)	CHA	eco77	e b	ALL,	MÍ	)		
DH	Regist	rar	JAN 2 2 2004	Bear	H A	GINAL								
					UKI	GINAL								

			-	For Amend Item 27 pe	State of Mar ME,G829,03	aryland /20/04di	Departs Depart	artment of rtificate o	f Health and N of Death	Mental Hy	/giene Reg. No.	2004	03626
		ysicia	_	1. Decedent's Name <i>(First, Middle, La</i> Leona Worga		_				2. Date of De Januar		, 2004°	3. Time of Death 8:34 P M
		ledica amine		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town	n, or Location of Death	1		County of Deeth	
			ı	Southern Marylan	d Hospital				linton		P	rince Geo	orge's
	Fun Direc			5. Social Security Number 6. S 262–38–6041	Sex 7. Ag I□M 2. OXF	e (In yrs. last 72	birthday) Yrs.	Months Day		8. Date of Bi	ay, Year)	Count	ace (State or Foreign try) Orida
	pu *	2286	-	Usuel Residence of Decedent  10a. State 10b. County		10c. City, T	own or Le	vestion				10	Od. Inside City Limits
200	farylan show	B 20	5		C 1 -								1 ☐ Yes 2 🖾 No
3	the Market	and and	Director	MD Prince  10e. Street and Number	George's	Upp∈	er. Ma	rlboro	θ.		10a. Citiz	en of What Count	try?
1/2	with 3a or	2		12305 Sturdee D	rive				772			USA	•
2	er death w	E E	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.		of Hispanic Origin? (Scuban, Mexican, Puerto	ecity Yes or No	0- 1	4. Race - America	
13	5-0036 72 hours after death with the Maryland naturs!; or Items 23a or 28a-1 show	ă .	۵	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	40		1 ☐ Yes 2 🖾 N		nican, etc.)		Black, White, e  Specify: Wh:	
	5-003 72 hours	lica.	Completed	15. Decedent's E	ducation ade completed)	1	6a. Dece	dent's Usual Oc	cupation ne during most of worl	cina	16b. Kin	nd of Business/Ind	ustry
31	2121 od within gjene.	M e	du	Elementary/Secondary (0-12)	College (1-4or 5		life.	DO NOT use ret	rired) Programer	9	Fede	eral Gov	't NASA
de	d 21 filed w Hygien	를		12   17. Father's Name (First, Middle, Last,	1			nitharer	18. Mother's Nam	a (First Middle			UNADA
.M.	Maryland 212. d 2 should be filed within th and Mental Hygiene. 7 Is merked other then	0 0	Be	_	,		Mono	on.	Rachel		, maideri s		tcher
8	aryla should and Men	Tat I	၉	Leon  19a. Informant's Name/Relationship (	Type, Print)		More 19b. Mailir		eet and Number or Ru		er. City or		
	e, Ma 1 and 2 : Health ar	Trac	-1	Wary Ann Barbour	daughter (daughter			-	om Station				
40	altimore, mit. Pages 1 au partment of Hea	othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other p	T			ation - City or Tov	
1	Page Page	ילי פו	- 1	1 ☐ Burial 2 ★Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify		Lee C			1	04	Clir	nton, MD	
18	Baltimor permit. Pages Department of Important: If Its	ic in	1	21. Signature of Runeral Service Licer	nsee		22	2. Name and Ad	dress of FacilityLee	Funera	l Hon	ne Calve	rt, PA
100	<b>a</b> 88 <b>E</b>	a a	1	Gary J.					thern Mary			Owings,	MD 20736
1	क ्र	<i>e</i> -		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. [	Do not ent	er the mode of o	tying, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physic	_	1	Immediate Cause (Final disease or condition resulting in death)	a PULL	AUN A	24	EDE	MA	Ar a			Onser and Death
B	/Med Exami	-		Tosuming in doubly	Due to (or as			C.2.1	14	5			
3		3	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	Z Z T		2000	n	3	-		
3	nted uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	EMP	445	EM	A	Jan CK	003			
ar	O, exec			resulting in death) Last	Due to (or as	a consequen	ce of):		( Jan 18 )				
	8760, cate be executed ohysician and	ng eu	dical	•	d. 057	FOP	0056	1515	And I				
)				IF FEMALE:					*				
2	Box 6 eath certifi	for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	ath 3[	Ectopic pregna			23	3d. Date of deliver Month	y Day Year
3	ords, P.O. Box 6 re uires that the death certifi een signed by the attending I	ped:	Completed by Physician/Me	1 ☐ Yes 2 X No 9 ☐ Unknown	4∏Pregnant at 9☐ Unknown	time of death	5 [	Other (specify)					, , , , , ,
00	P. (hat the ed by	detached	F .	Part II. Other significant conditions of	contributing to death be	ut not resultin	g in the u	nderlying cause	given in Part I.	23e. Did t	obacco us	e contribute to the	e cause of death?
12	ds, F uires tha	should be	Q D		LEET	HIP	FRA	SCTUI	28	10	Yes 2□	No 3⊠Proba	bly 4 DUnknown
3	() > 0	shou	lete							24a. Was	an	24b. Were autop	sy findings available
2	Vital Recipion: The law	age 2	E O		-					auto perfo	psy ormed? 22 No	prior to com death? 1 \( \text{Yes} \) 2	pletion of cause of
2	riffica	ō	Be C	25. Was case referred to medical					26. Place of Deat			10163 2	ELL NO
2	- 8 ×		0	examiner? 1 X Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ER	Outpatien	t 3 DOA	Other: 4 Nursing Ho	me 5 Resi	dence 6	Other (Specify)	
1	Vision of Vita Attending Physician: r death sctor: Aler this certific	nera	on:	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injui	y Ye <i>ar)</i> 281	o. Time of Injury	17 V		28d. Describe		occurred	
,	Sio tend	the	ca	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		1	( ° = =		☐ Yes 2 ☑ No				
	Division tal or Attending rs after death.	ed in by	Certification:	4 Homicide determined	building, etc	c. (Specify)	h	one		Drive	wn, State)	er more	strakle.
	Division To the Hospital or Attendent Within 24 hours after death To the Funeral Director:		Medical	29a. Certifier  (Check only one)  2 Medical Example (Check only one)	nysician: To the best on miner: On the basis of and manner sta	examination	dge, death and/or in	n occurred at the vestigation, in m	time, date and place, y opinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as sta place, and due to t	ted. Man land
	To th within To th	Eoo	Σ	29b. Signature and title of certifier					ense number		29d. Date	signed (Month, D	ay, Year)
				promos	ons			1)2	18128		JAN	22, 20	104
	10			30. Name and address of person who SISOM OSIA, M.	completed cause of d			Print)	STE 500	UNXO	14111	MD	20745
		Stat	е	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		1-4-32	3		.,		, , ,
	Re	gistra	r	JAN 2 6 201	14 /	H	Ano	M. 16					
	DHMH 17 Re	ev 1/200	01		6 Car 3 4	200	the same	- W.S.					

ORIGINAL

			For State Registrar	State of Mary		artment of I			iene 200	4 03627
- 4			1. Decedent's Name (First, Middle, Las	")		·		2. Date of Dea Month		3. Time of Death
	Physicia /Medic	20	JOHN EARL MOODY			1			23, 2004	7:30 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give				or Location of De	eath	4c. County of De	atn
100	Funeral		CIVISTA Medical 5. Social Security Number 6. Se	7. Age (II	n yrs. last birthday)	If Under 1 Year			Charles 9. B	rthplace (State or Foreign
	Director		216-34-7540	X <sup>M 2□ F</sup> (	56 Yrs.	Months Days	Hours M	DEC 28		yland
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
	Maryi f sho	tor	Maryland Charles		Waldorf					1 Yes 2 No
	h the	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?
	ath wil	ral	2500 Green Pine C			2060			USA	and an Indian
	er de:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?	er in U.S.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - An Black, Wh	
920	urs aff	by	3 Widowed 4 Divorced	1 WYes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify: W.	hite
21215-003	72 hours after death with the Maryland instural; or Itema 23e or 28e-f show Josef Examilier must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-		(Give	dent's Usual Occu	during most of	working	16b. Kind of Busines	s/Industry
121	filed within Hygiene. Ither than "	ldw	Elementary/Secondary (0-12)	College (1-4or 5+)		med Forc			National :	Security
0	Hygie other	a l	12 17. Father's Name (First, Middle, Last)		100 111	med Tole		Name (First, Middle,		Security
<u>a</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or itama 23a or 28a-f ahow aumatic event, the Maulcal Exemitret must be notified a	To B	John Moody				Cathe	rine Rober	tson Love	less
Maryland	2 should and Men ie marke surnatic		19a. Informant's Name/Relationship (7					r Rural Route Numbe		
	is 1 and 2 should of Health and Mer Item 27 is marks other traumatic		Katherine D. Mood		20b. Place of Dispo	osition (Name of		rt Waldo:	rf, Maryla 20c. Location - City o	
JO L	Pages nent of i int: If it		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, cre faryland	matory`or other pla Veterans		29 <b>–</b> 04	heltenham,	, MD
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signatur / Funeral Service Licen	200	4001/2	2. Name and Addr	1	Eberwein F		
170			23a. Party. Enter the disease, or semi	Dications that caused the	e death. Do not en	433 Whit ter the mode of dy	e Pls. I ring, such as care	La. White diac or respiratory are	Pls., MD	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			n Law.	d.c	C		Onset and Death
	/Medical		resulting in death)	Due to (or as a c	consequence of):	1.151.2	91360			1110000
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	ensequence of):	esterol	EMECA			Toyears
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	-						
o,	death certificate be executed e attending physician and nd for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a c	consequence of):					
8760,	icate be physici s the bu	dical	•	d			1878			
9	eath certific attending p	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of					23d. Date of c	lelivery
Box	death e atter d for u	Physiclan/Med	in the past 12 months?	1 Live birth 2 ( 4 Pregnant at tim		□Ectopic pregnan □ Other (specify)	cy		Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	9⊡ Unknown				an- Bida-	h	to the cause of death?
	sign Sign	by	Part II. Other significant conditions of	ontributing to death but i	not resulting in the t	underlying cause g	given in Part I.			Probably 4 DUnknown
Records,	0 5 0	Completed						24a. Was a autop perfor	sy prior to med2 death	autopsy findings available of completion of cause of ?
ital	iician: Th certificate rector, paç	BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only or		
<u>&gt;</u>	y S	ြင	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient		HIL SLI DOA		ng Home 5 Resid		pecify)
ouc	ding P h. After funera	tlon:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Y	/ear) 28b. Time (	W	uryat ork? ⊡Yes 2⊡No	28d. Describe n	ow injury occurred	
Division of Vital	for Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		r - At home, farm, si (Specify)	treet, factory, office	8	28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
_	Hospita 24 hours Funeral	edical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of one of the basis of each of the basis of the basis of each of the basis of	xamination and/or ii	th occurred at the nvestigation, in my	time, date and p	place, and due to the concourred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the comple	Me	29b. Signature and title of certifier	~		29c. Lice	nse number		29d. Date signed (Mo	
			1 Mitas	uBoyce	-111/m	DH	17563	3	01193	ISCOH
	BLEI		30. Name and address of person who Rita DuBoyce, N				AFB Cli	nton, MD 2	0762	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 8	32. Registrar	s Signature			•		

			1 - For State Registrar Amend Item#28	State of Maryland fperMEOG2/9/04Ew		rtment of Heatificate of De			ene 200	4 03628
	Discosia i		1. Decedent's Name (First, Middle, Lat			1 1		2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		JAMES	RYAN	MILE	RTIN		JAN	15 70	641840m
	Examin	er	4a. Fecility Name (If not institution, give	e street and number)	#73	4b. City, Town, or Lo	- /	15	4c. County of De	eath
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	f Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign
	Director		003-64-6008	2 M 2 □ F 2	5Yrs.	Months Days	Hours Min.	Sept. 8,	1978 N	lew Hampshire
	and w		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Manyl. f aho	io		7	analia					1 to Yes 2 □ No
	r 28a	Director	Maryland Anne A	arundel Ann	apolis	10f. Zip Code		100	g. Citizen of What	Country?
	23a c		72 Maryland Avenu	ie		21401		τ	Jnited St	ates
	er dez	nue	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of Hispa Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto l	cify Yes or No- Rican, etc.)	14. Race - Ai Black, W	nerican Indian, hite, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:	1	☐Yes 2 No	Specify:		Specify: V	<i>h</i> ite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ahow the Madical Examiner must be notified at	Completed by Funeral	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	ent's Usual Occupation	on ing most of worki	16	3b. Kind of Busine	ss/Industry
2	within iene. then "I	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	oo NOT use retired) stems engi	-	.9		
	filed v Hygie other t		17. Father's Name (First, Middle, Last,	<u> </u>	27			(First, Middle, Ma	engineeri alden Sumame)	.ng
<u>a</u>	Mental Mental arked o	To Be					Betty	unknown)		
Maryland	and and s m	-	James E. Martin 19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street and		,		a, Zip Code)
	1 and 2 Health tem 27 i		Michael Martin/	ıncle		Turf Valle				
٥	ages 1 nt of H : if ite		20a. Method of Disposition  1 Burial 2 Cremation 3	THE HOUSE HOLL STATE		sition (Name of latory or other place) s Cemetery	1	16, 2004	c. Location - City  Annapo	
Baltimore,	permit. Pages Department of the Important: if ite any injury or of once.		<ul><li>4 □ Donation 5 □ Other (Specifical Service Licer)</li><li>21. Signature of Funeral Service Licer</li></ul>			Name and Address				eral Home, Inc
B	Depa Impo any ir		J Scott 1	Committe	14	7 Duke of				s, MD 21401
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	i. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arres	t,	Approximate Interval Between
	Physician	Č.	Immediate Cause (Final disease or condition resulting in death)	a Hophy	IXIF	-				MINUTE
Н	/Medical Examiner		resulting in dealtry	Que to (or va constitu	ience of):					MINUTE
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a constitution	uence of):	-		-		Pull at Co
	rcuted nd transit	Examiner	Cause (Disease or injury that initiated events	c						
,8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
687		edlcal		d						
Box	ires that the death certiff signed by the attending d be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ncy death 3	Ectopic pregnancy			23d. Date of	· ·
O. B		sicle	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of de		Other (specify)			Month	Day Year
<u>α</u>	that the	Phy	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	deriving cause given	in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ds,	law requires that the as been signed by th 2 should be detache					,		1 ☐ Yes	2 <b>/</b> ⊠No 3□	Probably 4 Unknown
Record	aw requir s been si 2 should l	Completed						24a. Was an	24b. Were	autopsy findings available
<u>~</u>	Physicien: The lav r this certificate has ral director, page 2 a	Com						autopsy performe	ed? death	o completion of cause of ? es 2□ No
Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death	(Check only one)		
of	Physic rthis ral dir	. To	1  Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatien 28b. Time of		The second second second	ne 5 X Residen 28d. Describe how	ce 6 Other (S	pecify)
O	Attending It death. ector: After by the fune	atlon	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Mynth, Day Year)	UNI	28c. Injury at Work? ∠ M 1 ☐ Yes	s 2/11/No	HUN	9 50	14-
Division	Il or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 ☐ Could not be determined		me, farm, stre	et, factory, office	1	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
ō	urs afte			1	Home				State) Ave#8 Ann	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	nysician: To the best of my knowniner: On the basis of examinate and manner stated.	wledge, death tion and/or inv	occurred at the time, estigation, in my opin-	date and place, a ion, death occurre	and due to the cau ed at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	an De	eput	29c. License n			I. Date signed (Mo	nth, Day, Year)
)			Mille	-Dentes	mo	De	1605	4	1/12	14
			30. Name and address of person who	completed dauge of death (Item	23a) (Type,	Print)	-1	0000	1 00	1035
	- Cto	to	31. Date filed (Month, Day, Year)	32. Restrar's Signa	rure 1	0 127	2 /As	nerie	N 0	1000
	Sta Registr		JAN 15	2004	N. A	Coule				

Gene M. Moschetto

gierie Reg. No.	2	n	n	L	0	2	6	9	
Reg. No.	Seato.		(J)			V	U	5	

		1. Decedent's Name (First,	Middle, Las	st)				-	2. Date of D	eath			3. Time of Death
cian				,					Month	Da		Yeer	
dical		GENE MOSCE  4a. Facility Name (If not insi		a street and no	(mhar)		4b City Tourn	or Location of De	Janua		0 200		1132 a
iner	r		_		uniber)				241	1	J. County	OI Dealli	
		3804 Potee 5. Social Security Number	6. Se		7 Age //	n yrs. last birthday)	Balti If Under 1 Year		'S. 9 Date of B	irth		9 Right	place (State or Fore
l r	ľ			XM 2□ F		1 Yrs.	Months Days	Hours Mi		ay, Year	952	Cour	INGTON D.
4	-	UNKNOWN Usual Residence of Decede	ent			, <u>T</u>	1		JUHA Z	<i>J</i> , +	7.7.2	WELDILL	indion b.
		10a. State 10b. C			10	Oc. City, Town or Lo	ocation	-				1	I 0d. Inside City Limi
5	0	MD T	ALBOT	4		EASTON							1 ☐ Yes 🌠 ☐ N
Director	e	10e. Street and Number	LILIBOI			2011	10f. Zip Code			10g. Ci	itizen of W	Vhat Cour	ntry?
C	2	27776 SHARE	. DIN				216	:01			US	Λ	
Funeral	era	11. Marital Status	KD.	12. Was Dec	cedent Eve	r in U.S. 13.	Was Decedent of H		(Specify Yes or N	io-			
Ē		1 Never Married 2	] Married		2 <b>Z</b> No				erto Hican, etc.)		Black, White, etc.		etc.
ş		3 ☐ Widowed 4 🛣 Div	rorced	If Yes, G Year or I			1□Yes 2ĀNo	Specify:			Specify	WH]	LTE
ted	e e	15. De	cedent's Ed	lucation	0	16a. Dece	dent's Usual Occup	pation		16b. K	Kind of Bu	siness/In	dustry
Completed	ble.	(Specify only Elementary/Secondary (0		de completed) Cotlege (	(1-4or 5+)	life.	kind of work done DO NOT use retire	d) most of w	onking				
mo	Į į	12	,	Ö		M.	ANUEL LAF	BOR		CO	NSTR	UCTI	ON
4	D I	17. Father's Name (First, M	liddle, Last)					18. Mother's N	ame (First, Middl	e, Maider	n Surnam	ө)	<u>-</u>
TOB		ALBERT MOSO	ንተምምግ	)				NORM	RMA MYERS				
any injury or other traumatic	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Cit									ber, City	or Town,	State, Zip	Code)
	NORMA REDELE'/MOTHER 27776 SHARP RD. EASTON, MD 21601												
	1	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City										City or To	own, State
	1	20a. Method of Disposition    Date   20c. Location - City or Town,											
1	T		-					ss of Facility					<i></i> ,
	- 11	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERA 200 S. HARRISON ST EASTON, MD 21601											
		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final	se, or comp	plications that	caused the each line.	death. Do not ent	ELLOWS, I 00 S. HAF	IELFENBE RRISON S			FUNE 2160	RAL F	Approximate Interval Between
d	5	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate	ise, or comp b. List only	polications that one cause on Sei.	caused the each line. zure D	Ron F	ELLOWS, I 00 S. HAF	IELFENBE RRISON S			FUNE: 2160	RAL F	Approximate
al Examiner	al Examiner	shock, or heart failure Immediate Cause (Final disease or condition	ise, or comp b. List only	b. Due to	caused the each line.  Zure D  (or as a co	e death. Do not ent risorder onsequence of):	ELLOWS, I 00 S. HAF	IELFENBE RRISON S			FUNE 2160	RAL F	Approximate Interval Between
ledical	legical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events	ase, or comp b. List only of	a. Sei.  Due to  C. Due to  d. 23c. If yes, ou 1   Live	caused the each line.  ZUTE D  o (or as a color of core as a color of	e death. Do not enti-  risorder  onsequence of):  onsequence of):  onsequence of):  oregnancy  Figure 12  Figure 13  Figure 14  Figure 14  Figure 15  Figu	ELLOWS, I 00 S. HAF	HELFENBE RRISON S ng, such as card		arrest,		e of delive	Approximate Interval Between Onset and Death
Physician/Medical	Friysician/medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 \[ \text{Yes} \] 2 \[ \] No	ise, or comp b. List only of	b. Due to  c. Due to  23c. If yes, ou 1   Live 4   Preg 9   Unkr	caused the each line.  ZITE D  o (or as a co o (or as a co o (or as a co o to (or as a co o to (or as a co o to (or as a co o (or as a co	e death. Do not enti-  risorder  consequence of):  consequence of)	ELLOWS I OO S. HAE ter the mode of dyi	HELFENBE RRISON S ng, such as card	ac or respiratory	arrest,	23d. Date Mor	e of delive	Approximate Interval Between Onset and Death
by Physician/Medical	by Physician/Medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregna in the past 12 months 1	ise, or comp b. List only of	b. Due to  c. Due to  23c. If yes, ou 1   Live 4   Preg 9   Unkr	caused the each line.  ZITE D  o (or as a co o (or as a co o (or as a co o to (or as a co o to (or as a co o to (or as a co o (or as a co	e death. Do not enti-  risorder  consequence of):  consequence of)	ELLOWS I OO S. HAE ter the mode of dyi	HELFENBE RRISON S ng, such as card	ac or respiratory	arrest,	23d. Date Mor	e of deliventh	Approximate Interval Between Onset and Death Onset and Death
by Physician/Medical	by Physician/Medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregna in the past 12 months 1	ise, or comp b. List only of	b. Due to  c. Due to  23c. If yes, ou 1   Live 4   Preg 9   Unkr	caused the each line.  ZITE D  o (or as a co o (or as a co o (or as a co o to (or as a co o to (or as a co o to (or as a co o (or as a co	e death. Do not enti-  risorder  consequence of):  consequence of)	ELLOWS I OO S. HAE ter the mode of dyi	HELFENBE RRISON S ng, such as card	23e. Did	tobacco Yes 2 s an opsy	23d. Date Mor	e of deliventh  ibute to th  3 Prob  Vere auto rior to coreatly	Approximate Interval Between Onset and Death Onset and Death
e Completed by Physician/Medical	e completed by Physician/medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregna in the past 12 months: 1	ise, or comp b. List only of	b. Due to  c. Due to  23c. If yes, ou 1   Live 4   Preg 9   Unkr	caused the each line.  ZITE D  o (or as a co o (or as a co o (or as a co o to (or as a co o to (or as a co o to (or as a co o (or as a co	e death. Do not enti-  risorder  consequence of):  consequence of)	ELLOWS I OO S. HAE ter the mode of dyi	Yen in Part I.	23e. Did 1  24a. Wa aut	tobacco  Yes 2  s an  ppsy  cormed?  2   No	23d. Date Mor	e of deliventh  ibute to th  3 Prob  Vere autorior to coreath?	Approximate Interval Between Onset and Death  any Day Year  the cause of death?  ably 4 Unknown  psy findings availat
o Be Completed by Physician/Medical	o be completed by Physician/Medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months 1	ise, or comp b. List only of anditions of	b. Due to  c. Due to  23c. If yes, ou 1   Live 4   Preg   Unkr	caused the each line.  ZITE D  o (or as a co  o (or as a co  utcome of p  birth 2 [  gnant at tirm  nown  death but n	e death. Do not entitisorder consequence of): consequence	ELLOWS I OO S. HAE ter the mode of dyi	Yen in Part I.	23e. Did 1 24a. Wa ayiti	tobacco Yes 2 s an appsy ormed? 2 □ No	23d. Date Mor	e of deliventh  ibute to th  The problem of the correction to correct the corr	Approximate Interval Between Onset and Death Onset and Death
To Be Completed by Physician/Medical	to be completed by Physician/Medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	enditions of	Due to  a. Due to  b. Due to  c. Due to  d. Preg gg Unkr  Contributing to contributing to contributing to contribution to cont	caused the each line.  ZITE D  o (or as a color of color	e death. Do not entrisorder consequence of): consequence	ELLOWS I OO S. HAE ter the mode of dying ter the mode of dying cause granderlying	Y  Yen in Part I.  26. Place of Dier: 4   Nursingry at	23e. Did 1 24a. Wa ayiti	tobacco Yes 2 san porsy ormed? 2 \( \sum_{0} \) sidence	23d. Date Mor	e of deliventh sibute to th 3 Prob Vere auto rifor to cor eath? Tes	Approximate Interval Between Onset and Death Onset and Death
Certification: To Be Completed by Physician/Medical	Certification: To be completed by Physician Medical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \) Unknown  Part II. Dther significant contains the past 12 months 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)  25. Was case referred to mexaminer?  1 \( \text{Yes} \) 2 \( \text{No} \) No  27. Manner of Death  1 \( \text{Natural} \) 5 \( \text{If} \) 12 \( \text{Notident} \) 3 \( \text{Suicide} \) 6 \( \text{O} \)	int ?	Due to  a. Due to  b. Due to  c. Due to  d. Preg 9 Unkr  Hospital: 1   28a. Date (Mor	caused the each line.  ZITE D  o (or as a color of or as	e death. Do not entitisorder  consequence of):	ELLOWS I OO S. HAF ter the mode of dyi  Description of the second of the	Y  Zen in Part I.  26. Place of Dier: 4 In Nursing yat kir?	23e. Did 1 24a. Wa auti yer seath (Check only Home 5 Res 28d. Describe	tobacco Yes 2 San spsy ormed? 2 No one) sidence how inju	23d. Date Mor	e of deliventh  ibute to the state of the st	Approximate Interval Between Onset and Death Onset and Death
To Be Completed by Physician/Medical Examiner	edical certification: To be completed by Physiciativinedical	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 1 — Yes 2 — No 9 — Unknown  Part II. Dther significant conditions of the past 12 months 1 — Yes 2 — No 9 — Unknown  25. Was case referred to mexaminer? 1 — Yes 2 — No  27. Manner of Death 1 — Natural 5 — Female Conditions of the past 1 — Yes 2 — No  29a. Certifier 1 — Cee	nedical  Pending  Description  Pending  Description  Pending  Description  Descript	Due to  a. Due to  b. Due to  c. Due to  d. Preg 9 Unkr  Contributing to contr	caused the each line.  ZITE D  o (or as a color of or as	e death. Do not entitisorder  onsequence of):  onsequence of):  onsequence of):  onsequence of):  oregnancy  Fetal death 3E  of death 5E  ot resulting in the u  2 □ ER/Outpatier  28b. Time of Injury  At home, farm, strespecify)  ony knowledge, deatl amination and/or in	ELLOWS I OO S. HAF ter the mode of dyi  Ectopic pregnanc Other (specify)  Inderlying cause grounderlying grounderlying cause grounderlying grounderl	Y  Yen in Part I.  26. Place of Date: 4 \( \text{Nursing} \) Nursing yat the?  I Yes 2 \( \text{No} \) No	23e. Did 1 24a. Wa auti yer 28d. Describe 28f. Location City or To	tobacco  Yes 2  s an posy ormed? 2 No one) sidence how inju	23d. Date Mor use control 2/No 24b. W p do 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e of deliventh  ibute to th  3 Prob  Vere autorior to core eath?  DY es  ar (Specif)  ar or Rura	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and D

State Registrar MANUA MAN 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

	1_ State		State of Ma	aryland / Dep			∕lental Hygi	ene	11 0000
	Registrar		-	C	ertificate of	Death		g. No. 4 U L	14 03630
an		me (First, Middle, Las I NICHOLS	st)				2. Date of Death Month	Day Y	3. Time of Death
cal		(If not institution, give	street and number)		4h City Town	or Location of Death	JANUARY	25,2004 4c. County of	· · · · · · · · · · · · · · · · · · ·
ier	57				CAMP S				
4	5. Social Security	Number 6. Se		R e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	GEORGE S. Birthplace (State or Foreign
	215-49-0	124	X M 2□F	21 Yrs.	Months Days	Hours Min.	NOVEMBER 5	5, 1982 G	UŶĂÑĂ
	Usuel Residence	of Decedent		10c. City, Town or	Location				10d. Inside City Limits
ŏ	MARYLAND	PRINCE GEOF	ACTAC	OXON HILL					1 ⊋Yes 2 ☐ No
Director	10e. Street and N		WID .	CACH IIIII	10f. Zip Code		100	g. Citizen of Wha	Λ
	1124 WESTE	TELD DRIVE			20746		}	JUYANA	a country.
runeral	11. Marital Status		12. Was Decedent B	Ever in U.S. 13	. Was Decedent of I	Hispanic Origin? (Sp	ecrity Yes or No-	14. Race -	American Indian,
Ž	1 Never Ma	rried 2 Married	Armed Forces? 1 ☐ Yes 2 24N If Yes, Give	10	1 Yes 2 No	oan, Mexican, Puèrto	Rican, etc.)		White, etc.
a by	3 Widowed	4 Divorced	Year or Dates:		TU Tes ZU NO	Specify:		Specify:	BLACK
ete	(Spe	15. Decedent's Ed ecify only highest gra-	lucation de completed)	(Giv	edent's Usual Occur e kind of work done	during most of work	ing 16	6b. Kind of Busin	ess/industry
Completed	12TH GRADE		College (1-4or 5	+)	DO NOT use retire	9 <i>0</i> )		AN'ANT	
		e (First, Middle, Last)		UNIC		18. Mother's Nam	e (First, Middle, Ma	NONE	
To Be	GEORGE NIC	HOLS				EMELDA JON		,	
-	19a. Informant's I	Name/Relationship (7	Type, Print)	19b. Mai	iling Address (Street	t and Number or Run	al Route Number, (	City or Town, Sta	te. Zip Code)
	ARIAGNER P	BAKER / FLANC	EE			, N.W.#501,		-	010
	20a. Method of Di	isposition		20b. Place of Disp	position (Name of		Date 20	a Location Cit	
	. <b>10</b> 71 m			cemetery, cr	ematory or other pla	ice)	20	C. Location - City	y or Town, State
		Cremation 3  5 Other (Specify			ematory or other pla	ice)			
	° 4 ☐ Donation		)	RESURRECT	ematory or other pla	Y JANUAR	Y 31,2004		
	1 □ Donation 21. Signature of F	5 ☐ Other (Specify	sent John	RESURRECT	ematory or other pla ION CEMETERS  ORNION FUNE	Y JANUAR ERAL HOME, P	Y 31,2004	CLINION,	MARYLAND
	° 4 □ Donation 21. She ature of F	5 ☐ Other (Specify  Funeral Service Centre  THANION  the disease, or comp	see / / MO05	RESURRECT  83 34 the death. Do not e	ematory or other pla ION CEMETERS FUNION FUNE 439 LIVINGS	Y JANUAR ERAL HUME, P ION ROAD, IN	Y 31,2004 .A. DIAN HEAD,	CLINION, I	MARYLAND  20640  Approximate
	21. Stature of F  21. Stature of F  22a. Part1. Enter shock, or he Immediate Cause	5 Other (Specify  Uner Servi Centre  Thornion	UHNSON MOOS	RESURRECT  33 the death. Do not e	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR ERAL HUME, P ION ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	MARYLAND 20640
	° 4 □ Donation 21. Signature of F	5 Other (Specify  The Visit of the disease, or compart failure. List only of compart failure.	CHNSON MOO5 Dications that caused one cause on each limit.	RESURRECT  33 the death. Do not e	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Batween
	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death	5 Other (Specify Fuery Servi Cen  THANNIUN  TH	UHNSUN MO05  Dilications that caused one cause on each lin  Due to (or as a	RESURRECT  83  34 the death. Do not e.e.  44 a consoluence of):	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Batween
liner	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc.	5 Other (Specify Fusers Servi Cen.  THANIUN  The disease, or compart failure. List only of a (Final ion )  conditions, immediate berrying	UHNSUN MO05  Dilications that caused one cause on each lin  Due to (or as a	RESURRECT  83 30 the death. Do not e.e.	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Batween
amin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease ot that initiated even	5 Other (Specify Fusers Servi Cen Thaniun  Thani	Due to (or as a c.	RESURRECT  83 34 the death. Do not e.e. a consequence of):	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Batween
Examin	21. Signature of Full Library 23. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease to Cause (Disease	5 Other (Specify Fusers Servi Cen Thaniun  Thani	Due to (or as a c.	RESURRECT  83  34 the death. Do not e.e.  44 a consoluence of):	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Between
Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease ot that initiated even	5 Other (Specify Fusers Servi Cen Thaniun  Thani	Due to (or as a c.	RESURRECT  83 34 the death. Do not e.e. a consequence of):	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Between
Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unit Cause (Disease or that initiated even resulting in death)	The Company of the Co	Due to (or as a d.	RESURRECT  83 34 the death. Do not ele. a consequence of): a consequence of):	ematory or other pla  ION CEMETERS  CRITICAL  Address  ASSOCIATION  AS	Y JANUAR  RES OF FACILITY  RAL HOME, P  RON ROAD, IN	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	MARYLAND	20640 Approximate Interval Between Onset and Death
Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to icause. Enter Unic Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1:	THANIUN  The disease, or compart failure. List only of the disease	Due to (or as a d. Due to (or as a d	the death. Do not e.e. a consequence of): a consequence of): a consequence of):	ematory or other pla  ION CPMETERY  CRNION FUNE  439 LIVINGS  Inter the mode of dying  Company  Compan	JANUAR  SAL HOME, P  RON ROAD, IN  ing, such as cardiac	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	CLINION, I	20640 Approximate Interval Batween Onset and Death
Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unic Cause (Disease or that initiated even resulting in death)  IF FEMALE: 23b. Was decede	Thriun  The disease, or compant allure. List only of the disease or compant allure. List only of the disease or compant failure. List only of the disease or compant allure. List only of the disease or compant allure. List only of the disease or compant allure or company the disease of the d	b. Due to (or as a d. Due to (or as a d. 23c. If yes, outcome cause or each since the cause of t	the death. Do not e.e. a consequence of): a consequence of): a consequence of):	ematory or other pla  ION CEMETER)  ION THE STATE OF THE	JANUAR  SAL HOME, P  RON ROAD, IN  ing, such as cardiac	Y 31,2004  A.  DIAN HEAD,  or respiratory arrest	MARYLAND t.	20640 Approximate Interval Between Onset and Death
Physician/Medicai Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN J. the disease, or compart failure. List only of the disease of the disea	b. Due to (or as a d. 23c. If yes, outcome a liptopient in the lip	the death. Do not e.e. a consequence of): a consequence of): a consequence of): consequence of): consequence of):	ematory or other pla  ION CEMETRY  CRITICAL Address  Address  A39 LIVINGS  Inter the mode of dying  Shot  □ Ectopic pregnance □ Other (specify)	JANUAR  SAL HOME, P  RON ROAD, IN  Ing, such as cardiac  SAL HOME, P	Y 31,2004  A. DIÁN HEAD, or respiratory arrest	MARYLAND t.	20640 Approximate Interval Between Onset and Death
by Physician/Medicai Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN J. the disease, or compart failure. List only of the disease of the disea	b. Due to (or as a d. Due to (or	the death. Do not e.e. a consequence of): a consequence of): a consequence of): consequence of): consequence of):	ematory or other pla  ION CEMETRY  CRITICAL Address  Address  A39 LIVINGS  Inter the mode of dying  Shot  □ Ectopic pregnance □ Other (specify)	JANUAR  SAL HOME, P  RON ROAD, IN  Ing, such as cardiac  SAL HOME, P	Y 31,2004  A. DIÁN HEAD, or respiratory arrest	MARYLAND t.  23d. Date of Month	20640 Approximate Interval Between Onset and Death  delivery Day Year
by Physician/Medical Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN J. the disease, or compart failure. List only of the disease of the disea	b. Due to (or as a d. Due to (or	the death. Do not e.e. a consequence of): a consequence of): a consequence of): consequence of): consequence of):	ematory or other pla  ION CEMETRY  CRITICAL Address  Address  A39 LIVINGS  Inter the mode of dying  Shot  □ Ectopic pregnance □ Other (specify)	JANUAR  SAL HOME, P  RON ROAD, IN  Ing, such as cardiac  SAL HOME, P	Y 31,2004  A. DIÁN HEAD, or respiratory arrest	MARYLAND t.  23d. Date of Month  coo use contribut 2 10 No 3	Approximate Interval Between Onset and Death  delivery Day Year  te to the cause of death?  Probably 4 Unknown
by Physician/Medical Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN J. the disease, or compart failure. List only of the disease of the disea	b. Due to (or as a d. Due to (or	the death. Do not e.e. a consequence of): a consequence of): a consequence of): consequence of): consequence of):	ematory or other pla  ION CEMETRY  CRITICAL Address  Address  A39 LIVINGS  Inter the mode of dying  Shot  □ Ectopic pregnance □ Other (specify)	JANUAR  SAL HOME, P  RON ROAD, IN  Ing, such as cardiac  SAL HOME, P	23e. Did tobac	23d. Date of Month 200 use contribut 200 No 3	Approximate Interval Between Onset and Death  delivery Day Year  te to the cause of death?  Probably 4 Unknown as autopsy findings available to completion of cause of
Completed by Physician/Medical Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease chat initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	5 Other (Specify Fusers Servi Cen.  THANIUN  It the disease, or compart failure. List only of a (Final ion)  conditions, immediate ionly in a party may be in injury its  Int pregnant 2 months?  In No n	b. Due to (or as a d. Due to (or	the death. Do not e.e. a consequence of): a consequence of): a consequence of): consequence of): consequence of):	ematory or other pla  ION CEMETRY  CRITICAL Address  Address  A39 LIVINGS  Inter the mode of dying  Shot  □ Ectopic pregnance □ Other (specify)	y JANUAR  ASS OF FACILITY  PRAIL HOME, PRON ROAD, IN  Ing, such as cardiac of the second of the seco	23e. Did tobac  1 Yes  24a. Was an autopsy 1 Yes 2	23d. Date of Month  200 use contribut 200 No 30  24b. Were prior	Approximate Interval Between Onset and Death  delivery Day Year  te to the cause of death?  Probably 4 Unknown autopsy findings available to completion of cause of h?
Be Completed by Physician/Medical Examin	23a. Part 1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to icause. Enter Unicause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN  THA	b. Due to (or as a d. Due to (or	the death. Do not e.e. a consequence of):	Ectopic pregnance  Other (specify)  underlying cause give	y JANUAR  PAL HOME, P  ION ROAD, IN  Ing, such as cardiac of the second	23e. Did tobace 1 yes  24a. Was an autopsy performent (Check only one)	23d. Date of Month 2 10 No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death Death Onset and D
To Be Completed by Physician/Medical Examin	23a. Part 1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unc Cause (Disease or that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN  THA	Due to (or as a d.  23c. If yes, outcome of the pregnant at 90 Unknown ontributing to death but the properties of the pr	RESURRECT  183 34 the death. Do not e.e. a consequence of): a conseque	ematory or other pla  ION CHETRY  CRITION FUNE  439 LIVINGS  Inter the mode of dying  Cother (specify)  underlying cause give  ent 3□DOA	y  JANUAR  ASS OF FACILITY  PRAIL HOME, PRON ROAD, IN  Ing, such as cardiac of the such as	23e. Did tobace 1 Yes  24a. Was an autopsy performe 1 Yes 2 Con (Check only one) me 5 Residence	23d. Date of Month  23d. No 3  24b. Were prior dead 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death Death Onset and D
To Be Completed by Physician/Medical Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Enter Unic Cause (Disease or that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	THANIUN  THA	Due to (or as a d. Due to (or as	RESURRECT  83 3 the death. Do not e.e. a consequence of):	Ectopic pregnance  Other (specify)  underlying cause given  of Pin 28c. Injur  28c. Injur  28c. Injur	y  JANUAR  ASS OF FACILITY  PRAIL HOME, PRON ROAD, IN  Ing, such as cardiac of the such as	23e. Did tobace 1 yes  24a. Was an autopsy performent (Check only one)	23d. Date of Month  23d. No 3  24b. Were prior dead 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death  delivery Day Year  le to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of 10? Yes 2 No
To Be Completed by Physician/Medical Examin	23a. Part 1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to icause. Enter Unc Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	S Other (Specify Fueral Servi Cen.  Thaniun  the disease, or compart failure. List only of a (Final ion ion)  conditions, immediate bentying or injury its interest in the pregnant 2 months?  In No in increase of conditions conditions on investigation 6 Could not be	b. Due to (or as a d. Due to (or	RESURRECT  83  34  the death. Do not eight a consequence of): a conseq	DECtopic pregnance Other (specify)  underlying cause given the moder of the modern	y  JANUAR  SEAL HOME, P  ION ROAD, IN  Ing, such as cardiac or  year in Part I.  26. Place of Death  Ther: 4 \( \text{Nursing Hor  year  year  Yes 2 \( \text{No} \)  No	23e. Did tobace  23e. Did tobace  1 yes  24a. Was an autopsy performe 1 yes 2 in (Check only one) me 5 in Residence 28d. Describe how	23d. Date of Month  23d. Date of Month  22db. Were prior 24b. Were prior 24b. Were prior 25d injury occurred 25d injury occurred 25d injury occurred	Approximate Interval Between Onset and Death  delivery Day Year  de to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of the cause of the completion of cause of the c
o Be Completed by Physician/Medical Examin	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death  Sequentially list of any, leading to cause. Pure Tunc Cause (Disease or that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1	S Other (Specify Fueral Servi Cen.  Thaniun  the disease, or compart failure. List only of a (Final ion ion)  conditions, immediate bentying or injury its interest in the pregnant 2 months?  In No in increase of conditions conditions on investigation 6 Could not be	Due to (or as a d. Due to (or as	the death. Do not e.e. a consequence of): a consequ	DECtopic pregnance Other (specify)  underlying cause given the moder of the modern	y  JANUAR  SEAL HOME, P  ION ROAD, IN  Ing, such as cardiac or  yen in Part I.  26. Place of Death  Ther: 4 \( \text{Nursing Hor} \)  Yes 2 \( \text{No} \)  No	23e. Did tobace  23e. Did tobace  1 Yes  24a. Was an autopsy performe 24a. Was an autopsy 1 Yes 2 In (Check only one)  me 5 Residence 28d. Describe how  28f. Location (Streec City or Town, S	23d. Date of Month  23d. Date of Month  200 No 3  24b. Were prior dead  27 No 100  28 6 Other (Sinjury occurred www. Singer and Number of State) E40 1	Approximate Interval Between Onset and Death  delivery Day Year  le to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of here 2 No

Registrar

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

JAN 2 9 2004

29b. Signature and title of certifier

w.

m.is

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year) JANUARY 27, 2004

State

		1 - For State Registrar Amend Item#28a-	State of Maryland					ene 2001	03631
Phy	/sician	Decedent's Name (First, Middle, Last)	27770	7237			2. Date of Death	Day Year	3. Time of Death
//	ledical aminer	Joseph 4a. Facility Name (If not institution, give s.	Andrew reet and pumber)			Location of Death	JANKAR	4c. County of Dea	
		5015 Suit March 5. Social Security Number 6. Sex	7. Age (In yrs. I	last hirthday)	Scal	If Under 24 Hrs.	8. Date of Birth	Frince	thplace (State or Foreign
Fund Direct		212-72-3304	M 2□F 47	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Co	Maryland
rland	a	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Loc	ation		00000		10d. Inside City Limits
he Mary Sa-fath	Director	Maryland Prince Ge	orge's	Suitl					1 Yes 2 No
h with t	al Dire	10e. Street and Number 5015 Suitland Road			10f. Zip Code 20'	746	10	og. Citizen of What Co U.S.A.	ountry?
16 after deat or Items	Funeral	11. Marital Status 1 1 CXNever Married 2 Married 1	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	lf If	Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	te, etc.
-003 Phours	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a. Decede	ent's Usual Occupa	ation	1	6b. Kind of Business	White
Ind 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Nems 23s or 28s-f ahow	t, tre Medical	(Specify only highest grade Elementary/Secondary (0-12) 1.2.		(Give k	ind of work done of O NOT use retired,	furing most of work	king	Automobile	,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 ahow	To Be C	17. Father's Name (First, Middle, Last) Gerald G. Neil	l, Sr.				e (First, Middle, M A. Alvey	laiden Sumame)	
Maryla d 2 should th and Men 7 is marke	traume	19a. Informant's Name/Relationship (Type Gerald G. Nei						City or Town, State, .	
more, N Pages 1 and:	y or other	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	moval from State	lace of Dispos emetery, crem	ition (Name of atory or other place	Jan.	Date 2	t0c. Location - City or	Town, State
Baltin permit. P Departme Importan	any injury ODCB.	21. Signature of Funeral Service Ligense			Name and Addres	s of Facility	ee Funer	Clinton, Mal Home, I	Inc.
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death					Rd Clintor st,	Approximate Interval Between
Physic /Med		Immediate Cause (Final disease or condition resulting in death)	Cunshot		ud to	Head			Onset and Death
Exami	ner	Sequentially list conditions,	Due to (or as a consequ						
petno	Tal-transit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a currequ	uence of):					
8760, cate be executed	burial-tr al Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
Phy cate		d.							
E 9	letached for use as Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
T 5 8	p p	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
Records, The law requires I	, page 2 should						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vita vician:	director,	25. Was case referred to medical examiner?	ospital:		3C DOA Othe	Nr.	h (Check only one	)	
	<u> </u>	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe how		cify)
DIVISION OF Attendation death	in by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	1/7/2004  28e. Place of Injury - At ho building, etc. (Specify	Unknown  ome, farm, stre  Home		∕es 2.[X]No	Self Infl  28f. Location (Streetly or Town,  015 Suitla	eet and Number or Ri State)	ural Route Number,
Div the Hospital or hin 24 hours afte the Funeral Div	completely filled  Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	cian: To the best of my knower: On the basis of examinat and manner stated.	wiedge, death	occurred at the timestigation, in my op	e, date and place,	and due to the car	use(s) and manner as	s stated.
To the Within To th	compl	29b. Signature and title of certifier	10 -		29c. License	number	29	d. Date signed (Mont	h, Day, Year)
		30. Name and address of person who	noleted cause of death (Item	23a) (Type P	rint)	253-927	J	musy	8 roof
18 b		SALVADON Sylvel	Te, 300 Ho.	spita	1 Drin	y chen	kely	MANY /M	sd
Re	State gistrar	31. Date filed (Month, Day, Year)  JAN 2 1 20	32. Figistrar's Signal	ture for	nede		"		

		-	For State Registrar	State of Ma	rylan		rtment of F		d Mental H	/giene Reg. No.	/ 11111	03632
	Physicia		1. Decedent's Name (First, Middle, Last	DN C	f	EDD	CORD		2. Date of D Month	eath Day	Year 200 km	3. Time of Death
jį	/Medic Examin	_	4a. Fecility Name (If not institution, give				4b. City, Town, o	r Location of D			County of Death	1
	Examili	e,	Howard County Gene	eral Hospi	tal		Colu	mbia			Howard	Ē
	Funeral Director		5. Social Security Number 6. Se 112 01 7954	T	(In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B (Month, L June	irth 9y, Year) 21,19	9. Birth Cou	place (State or Foreign intry) yland
	ס		Usual Residence of Decedent	' '	10+ Cit	v. Town or Lo			<u> </u>			10d. Inside City Limits
	arylar ahow	_	10a. State 10b. County									1 ☐ Yes 2 🛣 No
	Ne M	Director	MD Howard  10e. Street and Number		EL	licott	10f. Zip Code			10g Citi	zen of What Cou	
	with t		4005 St. Johns Lar	ne			210	42			ited Sta	
	death ma 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.	S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or N		14. Race - Amer	ican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23e or 28e-f ahow other traumatic event, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Tyes 2XN  If Yes, Give Year or Dates:	lo		f Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No	Specify:	uerto Hican, etc.)		Black, White Specify:	nite
21215-0036	2 hou		15. Decedent's Ed (Specify only highest grad	ucation			ient's Usual Occup kind of work done		working	16b. Ki	nd of Business/I	ndustry
218	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retire	d)	g			
21	filed within Hygiene. other then "		8			For	eman	18 Mother's	Name (First, Midd			nty Governmen
Maryland	2 should be fill and Mental H Is marked ott	To Be	17. Father's Name (First, Middle, Last) Robert Brent Pedd:	cord			,		Elizabetl			
lan	2 sho and h ls ma	r G	19a. Informant's Name/Relationship (7			1			r Rural Route Num			1
	1 and Health Iem 27 other tr		Kelly C. Haire/Gra	anddaughte			6 Old Fre	ederick	Road Mar		tsville,	MD 21104
Ore	00		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐		0	emetery, crei	pherd Cer		22-2004		icott C:	
Baltimore,	permit. Peges Department of Important: If it any injury or c		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen.</li></ul>		0104		_					mily FH Inc.
Bal	permit. Peg Department Important: I any injury o		Shem Colla	s-wilk	e	4	112 Old (	Columbi	a Pike E	llico		, MD 21043
2	\$ \$		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused one cause on each lin	the deat		er the mode of dyll Mighty m ch		rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a conseq		reymon	, Q				Days
	Examiner	Jer	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence of):						
	ate be executed by sicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of);						
8760,	sicien buria			d		,						
687	ficate p phys	edlo	1000	d								
Вох	leath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			]Ectopic pregnanc	v			23d. Date of defr	
P.O. B	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
	that the		Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Dio	tobacco u	ise contribute to	the cause of death?
rds	quires n sigr uld be	ed by	COID SE	TIC St	100	- , R	espira	tory	1)2	Yes 2	□No 3□Pro	bably 4 Unknown
Records,	aw requir is been si 2 should	Completed	failure						24a. Wt	ODSV	24b. Were au	topsy findings available completion of cause of
R	The ate h	E							pe 1 ☐ Yes	formad? 2/11No	death?	2 No
/ita	cien: entific actor,	Be	25. Was case referred to medical examiner?						Death (Check only			
) <del>[</del>	hysic this c	2	1 ☐ Yes 2 ☒ No	Hospital: 1 Anpatie		ER/Outpatie			ng Home 5 🗀 Re			cify)
L C	Jing F	lon	27. Manner of Death  Natural 5 Pending  Accident investigation	(Month, Da	y Year)	Injury	Wo	rk? ]Yes 2 □ No		o riow iriqui	y occurred	
Division of Vital	Attending Physicien: r death. sctor: After this certificator, by the funeral director, by	fical	3 Suicide 6 Could not be	28e. Place of In	ury - At h	ome, farm, st	reet, factory, office		28f. Location			ral Route Number,
Ö	s after s after el Dire ed in b	Certification:	4  Homicide	building, et	c. (Sp <del>e</del> cii	ry)	NAME OF THE PARTY		City of I	own, State	)	
	To the Hoapitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	65.5	ysician: To the best niner: On the basis of and manner st				and the control of a particular	management as about about		delicas and disco-	to the series/e)
	To the To the	₩	29b. Signature and title of certifier		1		29c. Licen	se number	~~X	29d. Da	te signed (Monti	n, Day, Year)
			Prita	em Si	,			1287	10	20	2192	004
(),	02		29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who  9 1 0 1 CHERR  31. Date filed (Month, Day, Year)  JAN 2 0 2	completed cause of d	leath (Iter	m 23a) (Type	Print) (R)	TAM	SSAIMI	MA	2070	8
Y	VC1	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ature > U	1 12 2	411 6	nurer /	17		
E	St Regist		JAN 2 0 2	104 Been	رسا	B. A	and the					

			For State	State of Maryla		artment of h				/	4 03633
	8 6		Registrar  1. Decedent's Name (First, Middle, Las	st)		illicate of	Deam		2. Date of Deat	h	3. Time of Death
	Physicia		Lucille Almena Pi						Month January	6, 2004	4:54 p M
	/Medic Examin		4e. Facility Name (If not institution, give			4b. City, Town,	or Location		canacy	4c. County of De	
			Washington Advent	ist Hospital		Takoma	Park			Montgome	ery
2	Funeral		5. Social Security Number 6. S	DM 253 E	i. last birthday) Yrs.		If Under	Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
ķ.	Director	-	168–14–1605 Usual Residence of Decedent	82	113.			- 4	4/20/192	21	PA PA
	yland		10a. State 10b. County	10c. C	City, Town or Lo	ocation			·		10d. Inside City Limits
	e Mar	ctor	MD St. Mary	's		Ca	liforr	nia			1 XYes 2 No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code	C10		11	0g. Citizen of What 0	Country?
	eath v	eral	44041 Flagstone	Way  12. Was Decedent Ever in	U.S. 13		619 Hispanic Ori	igin? (Spe	cify Yes or No-	USA 14. Race - Arr	nencan Indian,
0	affer death with the Marylar or Items 23a or 28a-f show	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of I			Rican, etc.)	Black, Wh	ite, etc.
3	rel', o	þ	3 \ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2Ã No	Specify:			Specify:	White
ה	"naturel",	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	t of workin	ng	16b. Kind of Busines	s/Industry
7	within ene. then "	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		Resourc		riali	st I	U.S. Gove	nment
2	be filed within 72 hours after death with the Maryla tial Hygiens and a cheer than "netured", or tlems 23a or 28a-f ehov event, the Madical Exart set main be conflibed at	Be Co	17. Father's Name (First, Middle, Last)	)	nullar	<u>Nesourc</u>				Maiden Sumame)	
la la		To B	Cyrus C. Housel				Ber	della	M. Smi	th	
ary	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Stree	t and Numb	er or Rurai	Route Number,	, City or Town, State,	Zip Code)
≥ 10`	s 1 and if Health item 27 other tr		Nadine Hiers/Niec			202 Adkin	s Road			aryland 2	20708
2	8°= 5		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State	cemetery, cre	matory or other pla					
Baitimo	t. Partiment intent	}	* 4 □ Donetion 5 □ Other (Specifical Service/Licer			tan Crem					, Virginia
n	Dermi Depa Impo any ii		17. U	1000	I	PO Box 43	0, Du	Ray nkirk	mond-word , MD 20	od Funera. 754	l Home, P.A.
١.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de-							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. SEVERE	Res	PIRATE	RY	10	SUFFIC	IENCY	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse		.01					Dave
	<u> </u>	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. HEART  Due to (or as a conse	auence of):	/KC	-				DAIS
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	SEVERE	AOK	Tic VA	ALVE	2	DECASE		YEARS
ĵ	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conse							
2/60	5 S	Ilcai	•	d							
χ Σ	death certifica e attending ph ed for use as th	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pred	nancy					20d Date of d	
X Q Q	attence for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fe	tal death 3	☐Ectopic pregnanc	Çy .			23d. Date of d Month	Day Year
j.	the d	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown							
ν, T	requires that the	y P	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	inderlying cause g	ven in Part I	١.	23e. Did tob		to the cause of death?
ä	equire sen siç ould b	ted	RIGHT VEN RENAL 11	I KICULAR I	SCHE	4//4			1 ☐ Ye	as 2 No 3 F	Probably 4 Unknown
Hecords	law ras be	nple	KENAL 11	NSUFFICIEN	CY				24a. Was ar autops perform	y prior to	autopsy findings available completion of cause of
ē	icien: The law certificate has rector, page 2 :								1 Yes 2	2 No 1 Ye	s 2□ No
Vitai		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 Inpatient 2	□ EP/Outpatie	nt 3 DOA Ot			(Check only on	e) ance 6 □Other <i>(Sp</i>	acitul
0	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time o	of 28c. Inju				ow injury occurred	outy
0	Attending F ir death. ector: After by the funer	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	n	injury .		Yes 2	No			
DIVISION	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		home, farm, st	reet, factory, office		2	8f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by			nysicien: To the best of my ki							
	n 24 t n 24 t he Fu pletely	Medical	one)	niner: On the basis of examination and manner stated.							
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licen	se number	-/	25	9d. Date signed (Mo	nth, Day, Year)
			Jam My	MD.	>	10	1827	/		1/6/09	
	D		30. Name and address of person who SAMIR R. N.  31. Date filed (Month, Day, Year)	completed cause of death (It	em 23a) (Type 76/	Print) CARR	OLL A	Av	TAKOMA	TARK,	MD, 209/2
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra's Sig	nature						
	Regist	ar	JAN U	8 2009 State	e, H.	spark	P				
DIE	MI 47 Day 4/0	001		-							

			1 - For State Registrar Amend Item	State ( State (#28a_fnorM)	of Maryla	nd / Depa o / ი/. <i>Ger</i>	artment c <i>rtificate (</i>	f Health of Death	and Ma h	ental Hy	giene Reg. No.	200	14 03	3634
29			Decedent's Name (First, Middle)	le, Last)	20020 27	J/OH DW				2. Date of De	aath	. V		of Death
	Physicia /Medic		Michael Harry	Pearlman						Januar	Day	7009	1	14 M
il.	Examin	_	4a. Fecility Name (If not institution		ımber)		4b. City, Tov	n, or Location	of Death			County of D		
			Bouchelle and	Mechanics	Valley	Roads		h East				Ceci		
	Funeral		5. Social Security Number	6. Sex 1. X M 2 □ F	7. Age (In yrs	s. last birthday)	If Under 1 Y Months Da	ear If Unde ays Hours	Min.	8. Date of Bit (Month, Da	th ay, Year)	9. 1	Birthplace (State Country)	or Foreign
- 65	Director		090-50-3174	I MALIMI ZUF	45	Yrs.				June 6	195		New York	
	and	}	Usual Residence of Decedent  10a. State 10b. County	/	10c. C	City, Town or Lo	cation						10d. Inside	City Limits
	Aaryl F sho	ō	Massal	_ # 1		E11-4							1 □ Ye	s 2X No
	28a-	Director	Maryland Ce  10e. Street and Number	cil		Elkton_	10f. Zip Co	de			10a. Citi	zen of What	Country?	
	with Sa or	<u>=</u>		Dood				01001			TT*	4 . 1 . C		
	ns 2%	era	985 Nottingham  11. Marital Status	12. Was Dec	edent Ever in	U.S. 13. V	Was Decedent f Yes, specify	21921 of Hispanic O	rigin? (Spe	cify Yes or No			merican Indian,	
39	urs after o	by Funeral	1 Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes G	2 X No ive		f Yes, specify o			Rican, etc.)		Black, W Specify: V		
15-0036	be filed within 72 hours after death with the Maryland lat hygiene d other then "natural", or Itams 23a or 28a-f show event, the Medical Examinet must be notified at	Completed	(Specify only highe	nt's Education est grade completed		16a. Deced (Give life. L	dent's Usual O kind of work d DO NOT use re	ccupation one during mo stired)	ost of working	1g	16b. Ki	nd of Busine	ss/Industry	
2121	filed withi Hygiene. Sther then	mo	Elementary/Secondary (0-12) 12	8 College	(1-4or 5+)	Pro	fessor				Ed	ucatio	on	
פ		Be C	17. Father's Name (First, Middle,	, Last)				18. Moth	her's Name	(First, Middle	, Maiden	Sumame)		
<u>a</u>	should be and Mental marked o umatic eve	70 0	Abraham Pearlm	an				Hele	en Gol	dsteir	1			
Maryland	2 should be and Mental is marked traumatic ev		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	ig Address (St	reet and Numb	ber or Rura	Route Numb	er, City o	r Town, State	e, Zip Code)	
	1 and 2 Health iem 27 l		Abraham Pearlm	an/Father			Box 44							
altimore,	1 tel		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Removal from		Place of Dispo- cemetery, cren	sition (Name o natory or other		Janua:	cy 5,	20c. Lo	cation - City	or Town, Stete	
Ē	Pages ment of I ant: If its jury or o		'4 □Donation 5 □ Other (	Specify)		ayerdal		atory	2004	-	Ne	wark.	Delawar	re
Bail	permit. Page Department of Important: If any injury or once.		21. Signature of June at Service	cense	0		. Name and A		OIC	uch Fu				
W.	003 e 0	_	1 Color	J. vier	1							ast, N	Maryland	
100 mg/s			23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one cause on	each line.			,	is cardiac of	respiratory a	rrest,		Approxima Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a G		Wound	to Hea	d					Immed	rate
6.X	/Medical Examiner		Toballing in doubly	Due to	(or as a conse	equence of):								
-24		-	Sequentially list conditions, if any, leading to immediate	b. Due to	for as a conse	equence of):							yeurs	<u> </u>
	ted nsit	Examiner	Cause (Disease or injury	< −	,									
	al-tra	Exai	that initiated events resulting in death) Last	C. Due to	(or as a conse	equence of):							-	
58760,	icate be executed physician and s the burial-transit	edical		d										
_													100000000000000000000000000000000000000	
Вох	attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pregn	ancy			2	23d. Date of	delivery	
	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (specif					Month	Day	Year
o.	at the de I by the a stached	Phy	9 Unknown											
Ś	law requires that the death certif as been signed by the attending 2 should be detached for use a.	by	Part II. Other significant condit	ions contributing to	death but not re	esulting in the ur	nderlying caus	given in Part	t I.				e to the ca <i>u</i> se of Probably 4	
Records,	w require been si should?	Completed								West Lines		1	Trobably 7 p	QO: MINO MIN
Sec.	e law has t	npl				-				24a. Was		24b. Were prior death	autopsy finding to completion of	s available cause of
	Th life									1 ☐ Yes		1 🗆 Y		
Division of Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only			Bouche	1/2 /210
ot	Phys rthis raldi	7	1 Ves 2 No 27. Manner of Death	11		☐ ER/Outpatien 28b. Time of		4 🗆 N		ne 5 Resi			ipecity) Meal	Velley de
o	ding Ph h. After th funeral	tlon	1 Natural 5 Pendi 2 Accident invest	ing (Mo	of Injury nth, Day Year) 1/2/2004	Unknown		Injury at Work? 1 ⊟ Yes 2 🔯		Self I				
/S	or Attendated steer death	fica	3 Suicide 6 □ Could	not be 28e. Plac	e of Injury - At	home, farm, stre				8f. Location (	Street and	d Number or	Rural Route Nu	mber,
5	after Dire	Certification:	4  Homicide	DUII	ding, etc. <i>(Spec</i> Baseball				В	City or To ouchelle			all Rd NE	. Md
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifyi (Check only one)	ing Physician: To the Examiner: On the	e best of my ki basis of examin	nowledge, death nation and/or inv	occurred at the	ne time, date a my opinion, de	and place, a	nd due to the	cause(s)	and manner	as stated.	
	o the	Me	29b. Signature and title of certific		3161.001		29c. Li	cense number	r		29d. Date	e signed (Mo	onth, Day, Year)	
	->-0		IN TOS	tim m	ס		D	5711	4		7.	uary !	5. 2004	
,	1		30. Name and address of person	n who completed car	use of death (Ite	em 23a) (Type,	Print)	/ ) /	1		Ukn	7	, 200-1	
	1		HFarkus 1	no Uni	m Hoso	ital, El	ik ton,	10 210	921					
	Sta		31. Date filed (Month, Day, Year	0 5 2004	Registrar's Sign	nature &	1. 1							
1900	Registi	ar	DITT	U U ZUU4	PARTIE AS	المحاكم السا	Attended							

			For State Registrar	State of Ma	ryland /		artment of tificate o			R	eg. No. Z	004	03635
*	Physicia /Medic		1. Decedent's Name (First, Middle, La Carl Wayne	Robertson,	Sr.					2. Date of Dea Feb. 1,		Year	3. Time of Death 6:15 PM M
r.	Examin		4a. Facility Name (If not institution, gi Beverly Health	Care Center			4b. City, Town Freder	ick			Fre	derick	
	Funeral Director			Sex 7. Age 1 M 2 ☐ F	(In yrs. last 75	birthday) Yrs.	If Under 1 Yes Months Day		B A inn	B. Date of Birth (Month, Day Jan. 11	, Year) 92	9. Birth Co.L 9 Okla	place (State or Foreign intry) Noma
	Maryland f show	tor	10a. State Maryland Freder	ick	10c. City. T Fred	own or Lo	cation						10d. Inside City Limits 1 Yes 2 No
	ier death with the Marylan Items 23e or 28e-f show Leff clust be notified at	al Director	10e. Street and Number 30 North Place				10f. Zip Code 217				10g. Citizer U.S.	of What Cou	untry?
336	72 hours after death with the Maryland netural; or tems 23s or 28s-f show disal Examination in the notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates: W			Was Decedent of If Yes, specify C			ecrfy Yes or No- Rican, etc.)		Race - Amer Black, White Decify: Whi	, etc.
21215-0036	C 20	Completed	15. Decedent's Is (Specify only highest g	Education rade completed) College (1-4or 5-	+)	(Give life.	dent's Usual Oci kind of work do DO NOT use ret ier/ Gla	ne during mo ired)				of Business/I	
land 2	uld be filed withir fental Hygiene. rked other than lic avant, me M	To Be Co	17. Father's Name (First, Middle, Las Crandle Ro					_	ner's Name Irene	(First, Middle, Jolly		ımame)	E1
, Maryland	1 and 2 should be Health and Mental tem 27 is marked of other treumatic avi		19a. Informant's Name/Relationship Mia Brust. Publi			19b. Maili 1440	ng Address (Stre Taney A	et and Numb	Frede	rick, M	laryla	and 217	′02
Baltimore,	nit. Pages 1 and: artment of Health ortent: If item 27 injury or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Contents)		сет	etery, crei Isburg	osition (Name of matory or other) Cremator	y ]	Feb. 3		Smith		Maryland
Balt	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Lic	They i	100255		Keeney ^9 106 East					Home k, MD 2	21701 Approximate
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each lin	eriat	ion	pneumon:		s cardiac c	or respiratory as	rest,		Interval Between Onset and Death 2 Days
	/Medical Examiner	J.		Due to (or as a b. Due to (or as a	d stag	e De	mentia-	Alzhei	mer				Yrs.
8760	ate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
.O. Box 68	requires that the death certificat een signed by the attending phy nould be detached for use as th	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3[	_Ectopic pregna _] Other (specify				23	d. Date of deli Month	ivery Day Year
rds, P.	quires that in signed build be det	ed by P	Part II. Other significant conditions Anemia	contributing to death be	ut not resulti	ng in the u	underlying cause	given in Pari	t I.		obacco use Yes 2		the cause of death? obably 4 _Unknown
Records,	elaw hasb je 2 st	omplet	Dsyphagia Gait Disorder							24a. Was autop perfo 1 🗆 Yes	osy irmed?	24b. Were au prior to death? 1 🗌 Yes	itopsy findings available completion of cause of
on of Vital	ding Physician:  After this certific	To Be	25. Was case referred to medical examiner?  1 Yes 2 X No  27. Magner of Death 1 X Natural 5 Pending investigat	28a. Date of Inju (Month, Da		NOutpatie 8b. Time o Injury	of 28c. l		Xrsing Ho	h (Check only one 5 Residence 28d. Describe	dence 6 [		cify)
Division	or Att	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be age Place of Init	ury - At hom- c. (Specify)	e, farm, si	treet, factory, off	ice		28f. Location ( City or To		Number or Ru	ural Route Number,
	e Hospital	ledical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner sta	f examination	edge, dea n and/or ii	th occurred at the	e time, date a ny opinion, di	and place, eath occurr	and due to the red at the time,	cause(s) as date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier	Reill	y.	ME		54749	r			2, 200	
_	1		30. Name and address of person with Allen Reilly,	M.D., 801 T	o11 H	ouse	Ave., D	-1, Fr	ederi	ick, Ma	rylan	d 2170	01
1	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatui	re	Bosch	3					

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Department of Health are Registrar  1- For State of Maryland / Department of Death  Certificate of Death	nd Mental Hy	giene Reg. No. 200	4 03636
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last)  BRIDGETTE THERESA REICH  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of	2. Date of De Month  Jan  Death	Day Yes 2 5 2 0 0 4c. County of D	4 22:08 PM
Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  9. Worth Days Hours  1 M 2 F 56  1 Usual Residence of Decedent		th 9.1	MICO Birthplace (State or Foreign Country) Ceorgia
17215-UU36 within 72 hours after death with the Maryland ene. than "naturat", or items 23s or 28s-f show the Madical Evanirer must be notified at	rector	10a. State 10b. County 10c. City, Town or Location Salisbury  10a. Street and Number 10f. Zip Code		10g. Citizen of What	10d. Inside City Limits 1 XYes 2 □ No Country?
death with ms 23a or must be	Funeral Director	611 W. Railroad Avenue 21801  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify Yes or No	U.S.A	mencan Indian,
ours after oursel; or iter	þ	1 Never Married 2X Married 1 Yes 2 No	Puerto Rican, etc.)	Black, W Specify: W	
ING 21215-UU36 be filed within 72 hours after death with the Marylar tall Hygiene. Id other than "naturel", or Items 23a or 28a-f show only the Medical Evantier must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Homemaker	of working	16b. Kind of Busine	ss/Industry
	To Be C	Leroy Foreman Maure	s Name (First, Middle een Morris		
		19a. Informant's Name/Relationship (Type, Print)  Frederick Paul Reich  19b. Mailing Address (Street and Number P.O. Box 4122 Sal	lisbury, M	D 21803	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item ony injury or other once.		20a. Method of Disposition  1		Frankford William S	, DE
D PO P		Burbage Funeral  23a. Fact 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as ca			21811 Approximate
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a obsequence of):	24		Interval Between Onset and Death  Thy  2-3 Mus
8760, rate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	Maré de		
cords, P.O. Box 68  wrequires that the death certifica been signed by the attending ph should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of Month	delivery Day Year
rdS, P quires that n signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  Probably 4 Donknown
The lay ate has page 2	Completed	penphessi vasculais l'insufficiency		psy prior death	autopsy findings available o completion of cause of ? es 2 \sum No
Ysician ysician is certifi director	To Be	examiner?	of Death <i>(Check only only only only only only only only</i>	one) dence 6 Other (S	pecify)
on of ding Phy h. After thi funeral		27. Manner of Death  1. Natural 5. Pending (Month, Day Year)  28a. Date of Injury (28b. Time of Injury Work?		how injury occurred	
DIVISION Attendent after deat Director:	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Number or wn, State)	Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the occurred at the time,	cause(s) and manner date and place, and o	as stated. lue to the cause(s)
To the within :	Me	29b. Signature and title of certifier (29c. License number 1) 153	384	29d. Date signed (Mo	onth, Day, Year)
ETI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RODNEY A. WENRICH 1346 S. DIVISION ST.		ISBURY	mD 21804
St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Aggistrar's Signature		,	

			3-36-1615 12004,drw <b>Please</b> Lack,per	Type or Print in I				_	_	
FD,1	.d #14, ./20/20	0 0 4	ack, per For State Registrar	State of Marylar		artment of I ertificate of		_	ene2001	03637
	Physicia /Medic		1. Decedent's Name (First, Middle, L Helen C. F	ast) Rapheal				2. Date of Death Month January	Day Yee 5, 2004	3. Time of Death 6:45 P M
	Examin		4a. Facility Name (If not institution, gi Calvert Memorial	Hospital		Prince :	Frederick			lvert
	Funeral Director			Sex 7. Age (In yrs. 1	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 1, 1	9. B 924	irthplace (State or Foreign Country) Texas
	Maryland -f show	tor	10a. State 10b. County		ty, Town or L Fort V	ocation Vashington	n			10d. Inside City Limits 1 □Yes 2√2 No
	h with the 23a or 28s	al Director	10e. Street and Number 6215 Dimrill C	Court		10f. Zip Code	0744	10	g. Citizen of What C USA	Country?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or Items 23a or 28a-f show reumatic event, it a M-dical Examination ust be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I.S. 13.	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	vithin 72 hounder.	Completed	15. Decedent's Elementary/Secondary (0-12)	Education	(Giv life.		during most of work ad)	ing	6b. Kind of Busines	s/Industry
and 21	e d a b e	Be Cor	17. Father's Name (First, Middle, Las Smalldest		гоss	istered N	T	e (First, Middle, Ma		assaint
_	s 1 and 2 should of Health and Men item 27 is marke other treumatic	-OF	19a. Informant's Name/Relationship Michael J. Roy		19b. Mai	•	and Number or Run 9 Borger,	al Route Number,	City or Town, State,	
Baltimore,	0 0 = =		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Spec	□Removal from State	Place of Disp cemetery, cre	osition (Name of ematory or other placetion Ceme	Jan'	D <b>at</b> O 20	oc. Location - City of	
Balti	permit. Pag Department Important: any injury c once.		21. Signa u e o Funeral Service Lico				ess of Facility Lee hern Mary			
•	Physician /Medical Examiner	ner	234. Part1. Enter the disease, or construction of lammediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	y one cause on each line.	quence of):	in	such as cardiac	toimm	st,	Approximate Interval Between Conset and Death Cary \$
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Cryss  Due to (or as a consecute)  d. Per c	quence of):		failure ai aton	Faile	<b>~</b> е	days
P.O. Box (	Physicien: The law requires that the death certificate be ex this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mookfis? 1 □ Yes 2 ₩ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of do	elivery Day Year
ds, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause gr	ven in Part I.	23e. Did toba		to the cause of death?  Probably 4 Minknown
l Recor	The law requate has been page 2 shou	Completed	Ur many Hypertens	tract infer	tim	,		24a. Was an autopsy performs	24b. Were a prior to death?	autopsy findings available completion of cause of
f Vita	Physicien: Th this certificate al director, pag	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	] ER/Outpatie	ent 3 DOA	har	h <i>(Check only one)</i> me 5 Residen	ce 6 □Other (Sp	ecify)
Division of Vital Records,	ol or Attending Phater death. I Director: After the din by the funeral	Certification:	27. Manner of Death  1 Matural 5 Pending investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury - At h	28b. Time Injury ome, farm, s	M 1□	rk? ]Yes 2 □No	28d. Describe how 28f. Location (Stre	et and Number or F	Rural Route Number,
Div	pite ours iera		29a. Certifier 1 Certifying F	building, etc. (Speci	fy) owledge, dea	th occurred at the ti	ime, date and place,		ise(s) and manner a	
	To the Hos within 24 hr To the Fun completely	Medical	(Check only 2 Medical Execution)  29b. Signature and title of certifier	eminer: On the basis of examination and manner stated.	ation and/or i	29c. Licens			e and place, and du	` '
	47-		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type	), Print)	20390 tal Rd.	Ponis	fredon	zk mo
	Sta Registr		31. Date filed (Month, Day, Year)  JAN (	32. Registrates Sign.	ature	Soule	10,90 tal Rd.	1		20678

			1 - For	use			nd / Dep	artmen	t of H	eaith a	and M	fental Hyg		egible.	An on an	
			Registrar	-11- 1	4)		Ce	rtificat	e of L	Death		R. 2. Date of Dea	eg. No.	2004	036	38
	Physicia /Medic		1. Decedent's Name (First, Mid Thelma ]	Eliz	abeth F							January	2 <sup>B</sup> / <sub>1</sub> <sup>y</sup>		3. Time of 0	
	Examin	er	4a. Facility Name (If not instituti Calvert Mem					Princ	e Fr		ick			County of Death		
	Funeral Director		5. Social Security Number 220 16 0394	6. Se	ox □M 2√F	7. Age (In yr 80	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day June 26	Year)	9. Birth Cou 3 West	olace (State or ntry) Virgin	Foreign 11a
	aryland show dat	<u> </u>	Usual Residence of Decedent  10a. State  Maryland  Calve	-			City, Town or Lo	ocation							10d. Inside City	-
	the M	recto	10e. Street and Number					10f. Zip	Code			1	0a. Citiz	en of What Cou		7.110
	th with 23s or	ai Di	846 Forest Gl	en 1	Road			1 .	557				_	ted Sta	-	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Evarifier must be nutified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Ma  3 Widowed 4 Divorce	7.7	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	<sup>2</sup> X No		Was Decedif Yes, spec		spanic Ori n, Mexican Specify:		ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh	etc.	
Maryland 21215-0036	hin 72 hou an "nature Medical E	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12)	est grad		1-4or 5+)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during most	t of work	ing	16b. Kin	d of Business/In	dustry	
7	ed with	Com	12				homer	naker	-					home		
/land	ould be fit Mental H srked oth	17. Father's Name (First, Middle, Last) Ernest Cline Laura Ha											Maiden S	Sumame)		
	ind 2 sho alth and I 27 is mu er trauma		19a. Informant's Name/Relation Theryl A. Danie			er	256 Kir	g Arth	ur Dr	. Wood	stoc	al Route Number K, Georgia	-		Code)	
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 □ Surial 2 □ Cremation 4 □ Donation 5 □ Other			State SO	Place of Dispo cemetery, crea lamans Me	osition (Name matory or o ethodis	ne of ther place t Cen	Jan 3 etery	30 200	Date )4 90		ation - City or To IS Marylar		
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service	e Licen								sch Funera Republic	al Home PA			
760,	hysician and hysician and burial-transit sthe burial-transit	lical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	or compositionly of	a. Response to the control of the co	cor as a consi	equence of):  Lucy equence of):  Lucy equence of):	ter the mod	e of dying	g, such as	cardiac o	or respiratory arm	est,		Approximate Interval Betw Onset and Da	reen
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ointh 2 ☐ Fe nant at time of	tal death 3	Ectopic pr					23	3d. Date of delive		ear
	uires that signed by Id be deta	by	Part II. Other significant condi	tions co	ontributing to d	eath but not r	esulting in the u	nderlying c	ause give	n in Part I.				e contribute to the		
Vital Records,	sician: The law requir s certificate has been si lirector, page 2 should I	Completed			-							24a. Was a autops perform	v /	death?	psy findings av	vailable use of
Vita	ician: Sertific ector,	Be	25. Was case referred to medic examiner?	-	Hospital:	/			Othe	N.FI		(Check only on				
ō	ding Physician: The I h. After this certificate ha funeral director, page	n; To	1 ☐ Yes 2 ☑ No 27. Manny of Death		28a. Date	of Injury	ER/Outpatier 28b. Time o		8c. Injury	at		me 5 🗆 Reside 28d. Describe ho			y)	
sion	eath. or: Aft	catio	E	tigation		th, Day Year)	Injury	М	Work 1 □ \	r ∕es 2 ☐ h	No					
Division	tal or Attenors after deather biractor:	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined	28e. Place	of Injury - At ing, etc. (Spe	home, farm, sti	eet, factory	, office			28f. Location (St. City or Town	reet and , State)	Number or Rura	il Route Numbe	er,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Diractor: After this certifics completely filled in by the funeral director, I	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Phy il Exam	iner: On the b	best of my k asis of exami ner stated.	nowledge, deat nation and/or in	h occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, th occurr	and due to the ca	use(s) a ate and p	nd manner as si place, and due to	ated. the cause(s)	
	To the within To the comple	Z	29b. Signature and title of certif		e	Corsel	ani	290	License	J ( C	8	29	F	signed (Month,	A	
	10		30. Name and address of person	40	completed caus	se of death (It	em 23a) (Type,	Print)	20	Y	W	) 6	100	e39		
	Sta Registr	_	31. Date filed (Month, Day Year)  AN 2 8 2004  32. Registrar's Signature													

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth January 23, 2004 **Physician** 12:55 PM MARGARET S. SCOTT /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner La Plata Charles Charles County Nursing & Rehab Center 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Days Months Hours 1□M 2□F Yrs. 78 206-18-1208 Director JAN 9 1926 Pennsylvania Usuel Residenca of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland ment of Haaith and Mantel Hygiene.

ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Charles TY∑Yes 2 □ No Maryland Waldorf Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2448 Indian Court 20601 Funeral USA 12. Wes Decedent Ever in U,S Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Registered Nurse Education 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be John H. Shifler Elizabeth Retberg Shifler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Greg W. Scott (son) 2448 Indian Court Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State Department Important: If any Injury or Metropolitan Crematory 1-25-04 Alexandria, VA 4 ☐ Dogation 5 ☐ Other (Specify) 21. Signature of Fareral Service Licensee 22. Name and Address of Fecility Eberwein Funeral Services M00173 4433 White Pls. La. White Plains, MD 20695 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician enc i for use es the buriel-transit Attending Physician: The law requires that the deeth certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown þ been signe should be o Completed 24a. Wes en autopsy performed? 24b. Were autopsy findings completion of cause of death? hes 1 Yus 2 No 1 ☐ Yes 2 ☐ No certificate diractor, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funerel 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred ours after deau.

••• Director: Ah.

in by the fire. 1 Naturel 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital of within 24 hours a To the Funeral D 150 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 52289

State

31. Date filed (Month, Day, Year) JAN 2 2004 32. Register's Signeture

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Nalin Mathur, M.D. 10 St Patricks Drive Waldorf, MD Suite 404

Registrar

			1 - For State Registrar	100 1	State of M	larylar	•	artmen rtificat				lental Hy	giene Reg. No	21	004	03640
			Decedent's Name (First, Midd	le, Last)								2. Date of De	ath		-	3. Time of Death
1	Physici /Medic	al	Raphael  4a. Facility Name (If not institution	n aire s	troat and number		<u>ith</u>	4b City	Town or	Location	of Death	Janua:	-	5 2	Year 2004 y of Death	12:22 p <sup>M</sup>
	Examin	er				,		,			erick		10		lvert	
	Formula		Calvert Memori  5. Social Security Number	6. Sex		ge (In yrs.	last birthday)		1 Year	If Unde	er 24 Hrs.	9 Date of Bi	rth			lace (State or Foreign try)
	Funeral Director		none		M 2DF		Yrs.	Months	Days	Hours 1	Min. 16	Jan. 5	ay, Year) 20	04	Mar	yland
			Usual Residence of Decedent					1			110	Julia 3	, 20		1111	ylana
	ylan		10a. State 10b. County	′		10c. Ci	ty, Town or L	ocation							10	Od. Inside City Limits
	Mar Be-f sl	호	MD	C	alvert			C	hesaj	peak	e Bea	.ch				1 ☐ Yes 2 ☒ No
	or 28	ie l	10e. Street and Number		-			10f. Zip	Code				10g. Cit	izen of	What Coun	try?
	23a	ai	6415 3rd Stre	et						207	32			US	SA	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show he Medical Examinar must be notified at	Funeral Director	11. Marital Status	1	2. Was Deceden Armed Forces	?	J.S. 13.	Was Deced	dent of Hi	ispanic C	rigin? (Span, Puerto	ecify Yes or No Rican, etc.)	o-		ce - America ck, White, o	
98	or It	耳	1 Never Married 2 ☐ Mai		1 ☐ Yes 2 ☐ If Yes, Give 2	7		1 🗆 Yes		Specif				Specii	fy:	
Ö	ural'	d by	3 ☐ Widowed 4 ☐ Divorce		Year or Dates	:	1 400 0000	ala mala I I a		-41			105 1	' C		ack
5	"nat	ete	15. Decede (Specify only highe	nt's Educ est grade	ation completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	during mo	ost of work	ing	16b. K	ind of E	Business/Ind	lustry
21215-0036	withir sne. than	Completed	Elementary/Secondary (0-12)		College (1-4o	5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	noi		,						
	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or items 23a or 28e-f show other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be natified at		17. Father's Name (First, Middle	Last)				1101		18. Mot	her's Name	e (First, Middle	, Maiden	Sumai	m <i>ə)</i>	· · · · · · · · · · · · · · · · · · ·
an	ould be Mental Marked o	o Be	Raphael	1110			Smith			RO	selin	6				Moshi
Maryland	S should be filed within and Mental Hygiene. Is marked other than aumatic event, tha M	ဥ	19a. Informant's Name/Relation	ship (Typ	oe, Print)			ng Address	(Street a			al Route Numb	er, City	or Town		
Z	and 2 sealth ar n 27 ls		Roseline Smith					P <sub>e</sub>	ox 2	06	Chesa	pake I	React	n N	(D) 20	732
ē,	1 and Health tem 27 other tr		20a. Method of Disposition	, 1110	CIPL		Place of Disp	osition (Nar	ne of			Date			- City or To	wn, State
Q	Pages nent of I ant: If its ury or of		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (		emoval from Stat		cemetery, cre Example				v n1/	13-2004	1 274	vər	dria	772
altimore,	그런 변경 .		21. Signature of Funeral Service		16/	10		2. Name ar				13-200	# AIC	-AUI	iai ia,	VA
Ba	permi Depa Impo eny i		William	D/	for			Rauscl	h Fui	nera	] Hom	e, P.A.	(	)wir	ngs, M	D 20736
1	Pnysician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complice t only on	Due to (or a	line.	ab	ter the mod		g, such a	Θ ,	or respiratory a	arrest,			Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last	ر د م	Due to (or a			\							83	
O. Box	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fet	al death 3	⊒Ectopic pi ⊒ Other (sp							ate of delive onth	ry Day Year
<b>Q</b>	uires that signed b Id be deta	ρ	Part II. Other significant condit	ions con	tributing to death	but not re	sulting in the o	inderlying o	ause give	en in Par	t I.			use con		e cause of death?
Records,	The law requir te has been si age 2 should l	Completed						_				24a. Was auto perfe 1 Yes			prior to con death?	osy findings available inpletion of cause of
Vital	ien: rtifica tor, p	Be C	25. Was case referred to medic	al						26. Pla	ce of Deat	h (Check only				
<b>f</b> \	Physicien: this certific ral director,	ToE	examiner? 1 ☐ Yes 25 No	н	ospital:	tient 2	] ER/Outpatie	nt 3 🗆 DC	Othe Othe	er: 4□l	Nursin <b>g</b> Ho	me 5⊟Res	idence	6 □Oti	her (Specify	)
ion of	fing After fune		27. Manner of Death  Death  Natural  Accident  The Pend  Inves	ing tigation	28a. Date of In (Month, E	jury Jay Year)	28b. Time of Injury	of 2	28c. Injury Work 1 🔲 `	yat k? Yes 2[		28d. Describe	how inju	ry occui	rred	
Division	el or Attendi s after death. Il Director: A sd in by the fa	Certific	3 ☐ Suicide 6 ☐ Couk 4 ☐ Homicide deter	I not be mined	28e. Place of I building,	njury - At I etc. <i>(Spec</i>	nome, farm, st	reet, factor	y, office			28f. Location ( City or To	Street ar wn, State	nd Numi ∌)	ber or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical Certification:			ician: To the besister: On the basis	of examin										
	To th Withir To th	ž	29b. Signature and title of certific	er		1		29	c. License	e numbe	r		29d. Da	te signe	ed (Month, i	Day, Year)
			Hich	De	65	5,2	ter	- 1	Do	00	515	814	T	2	0.5	2004.
			30. Name and address of perso	n who co	mpleted cause of	death (Ite	m 23a) (Type	Print)								,
			Michelle Johns	on,	M.D.,	10 H	<u>ospi</u> ta.	l Rd.	, Ste	e 21	1, Pr	<u>ince Fr</u>	eder	ick	, MD	20678
	Sta	ate	31. Date filed (Month, Day, Yea	)	32. Regis	strans Sign	ature	1								
	Regist	rar	JA	1 1	4 2000	DIMU	C. S.	GIN	A Carlo							

			Type or Print in E	Black In	delible Ink	c. Ensu	re All Copie	es Are	: Legi	ble.		
J. Smi	Lth		State of Marylan	d / Dep	artment of I	Health a	and Mental F	łygien	e o	001		
	1	For State Registrar		Ce	rtificate of	Death		Reg. N	10. ZL	104	03	64
		Decedent's Name (First, Middle, Las	t)			-	2. Date of			-	3. Time of	Death
Physiciar				1.	C		Month		ay	Yeer		М
/Medica		Anthony		mith,	Sr		Janua		8 200		649	_a
xamine	r '	4a. Fecility Name (If not institution, give			4b. City, Town,			4	c. County			
	4	Calvert Memorial	Hospital			e Fred			Ca.	lvert		
ral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date of (Month,	Birth Day, Year	r)	9. Birthpl	ace (State o	r Foreigi
		214-40-0807	X <sup>M 2□ F</sup> 64	Yrs.	Nontrio Dayo		Aug 2	6, 19	939		i. D.	
		Usual Residence of Decedent								122 11		
		10a. State 10b. County	10c. Cit	y. Town or L	ocation					10	0d. Inside C	ty Limits
3	Ö	MD	Calvert		Prince	e Fred	erick			ļ	1 🗆 Yes	2 N
9	Director	10e. Street and Number	341,010	· · · · · ·	10f. Zip Code	J 1100	01.1071	10a. C	itizen of V	What Coun	try?	
Ž	5	110 5								_	•	
3	Funeral	110 Dresser Avenu		0 10	20678	1111-1-1-1-0-1		Na	US		- Indian	
3	å.	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.5. 13.	If Yes, specify Cut	hispanic Orig ban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	140-		e - America k, White, e		
ű	Ξl	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2X No	Specify:			Specify	<i>,</i> ·		
	ğ	3 Widowed 4 Divorced	Year or Dates:						,	wh:	ite	
3	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occu	pation	of warking	16b. l	Kind of Bu	usiness/Ind	lustry	
5	a	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	ed)	or working					
1	E	11	College (1-401 54)	bric	klayer, d	contra	ctor		CO!	nstru	ction	
		17. Father's Name (First, Middle, Last)					r's Name (First, Mid	dle, Maide				
	Be	David Billmann Cm	.: L1.			Dles	Manai	- T/-	. 1 2 2.	-1-2		
F	္	David Fillmore Sm					nor Marie		_			
		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Stree	t and Numbe	r or Rural Route Nu	mber, City	or Town,	State, Zip	Code)	
		Angela E. Smith,	wife	110 1	Dresser A	Avenue	, Prince H	rede	rick	, MD	20678	3
		20a. Method of Disposition	1 ^	lace of Dispe	osition (Name of matory or other pla		Date			City or To		
		1 Burial 2 Cremation 3	Hemoval from State	-	-	!	04 00 04					
	+	* 4 □ Donation 5 □ Other (Specify	TIC				01-20-04	AL	exan	dria,	VA	
		21. Signature of Funeral Service Licen	500	2	2. Name and Addr	ess of Facilit	у					
		Wallon &	Jan-		Rausch Fi	uneral	Home, P.	Α.,	Owing	gs, M	D 20	736
Г		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the deat	h. Do not en	ter the mode of dy	ing, such as	cardiac or respirator	y arrest,			Approximat Interval Bet	e .
	- 1	Immediate Cause (Final	Athenselendic								Onset and	Death
ı		disease or condition resulting in death)	a		310 1000	uin i	31 Jense			_		
ı			Due to (or as a conseq	uence of):								
I.	.	Sequentially list conditions	b. ————————————————————————————————————									
13	Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
E	Ē	Cause (Disease or injury that initiated events	•									
13	Examine	resulting in death) Last	Due to (or as a conseq	uence of):								
13	Ø											
1	8		, d									
3	Physician/Medic	IF FEMALE:						- 1				
1	and a	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	cy		- 4		e of deliver		
3	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d	eath 5[	Other (specify)			-	Mor	11111	Day '	Year
97.50	Š	9 Unknown	9□ Unknown									
		Part II. Other significant conditions or	ontributing to death but not res	ulting in the u	inderlying cause gi	iven in Part I.	23e. D	id tobacco	use contr	ribute to the	e cause of d	eath?
1	٥	Chronic a	lcoholism				1	□ Yes 2	2 🗆 No	3 Proba	ably 4 Mil	Jnknown
4	Completed	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	70000									
100	be						24a. W	as an Itopsy	24b. V	Were autop	sy findings	availabl
1	E						, pe	nformed?	0	death?		2000 4.
	ပ	25. Was case referred to medical			<u> </u>	00 81	1 X Ye	-	0	W 103	2   110	
a	20	examiner?	Hospital:			26. Place	of Death (Check on	ly one)				
٤	0	1 24 142 5 140	1 Unpatient 2U		IL SIZION	4 🗆 140	rsing Home 5 R				)	
3	Ë	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	ury at ork?	28d. Descrit	e how inju	ury occurr	ed		
1	ä	2 Accident investigation		, ,		Yes 2 🗆 1	Vo					
4	2	3 Suicide 6 Could not be determined	286. Place of injury - At no	ome, farm, st	reet, factory, office	)	28f. Location			er or Rural	Route Num	ber,
920	Certification;	4 Homicide	building, etc. (Specify	y)			City or	Town, Stai	te)			
	2	One Continue to Continue Div			5 d - A A B - A		d ata a					
3	edical	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina									)
1	- G	one)	and manner stated.									
13	Σ	29b. Signature and title of certifier	~		1	ise number		1	_	(Month, D		
		hing his.	m.D			CME		Jan	uary	19 2	004	
	1			23a) /Tuna	Print)	-	TT 53					
		30. Name and address of person who o	completed cause of death (Item	∠38) (Type,		Denn C	treet, Bai	ltimo	re 1	Marcol	and 2	1201
					111 1	CIII 9	Leet, Da.	гстіЮ	LC, I	ин у т	шки 2.	
itate	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture								
tra	r	JAN 2 0 2004	Marine M	Ann. S	P 10							
/ 1/200	01		1 2000 0	A CONTRACTOR OF THE PARTY OF TH								
				ORIGIN	AL							

JOSEPH R.SILVER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-00184 Unpend Uniperior State of Maryland / Department of Health and Mental Hygiene TorAmend Items 1,23a,27,28a-T epr ME,6828,02/13/14dhb Registrar Certificate of Death Reg. No. DAP 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JANUARY 7,2004 Joseph Raymond Silver 7:18 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1103 SAN ANGELO DRIVE LUSBY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ 📈 2 🗆 F 82 266 10 9936 Director Aug 16 1921 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Calvert Lusby Director the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WITH ö 20657 United States 1103 San Angelo Drive itams 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Merital Hygiene. Important: if item 27 ia marked other than "natural", or itan any injury or other traumatic avant, its Medical Examinar, once. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecWhite ğ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) merchant marine Seaman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Ruth Allen James Raymond Silver 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 532 Acagona Blvd. Virginia Beach VA 23462 Jackie L. Teller sister 20b. Place of Disposition (Name of cometery, crematory or other place) Jan 11 Service Alexandria Virginia 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Is. RD.Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Head Injuries complicating chronic alcohol abuse **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an certificate has autopsy performed? 12 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6X Other (Specify) AT SCENE 1XYes 2□No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2X Accident 5 Strending Found Decedent fell down stairs 01/05/2004 1 ☐ Yes 2 🐴 No within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fu investigation 6:30p 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1103 San Angelo Drive, Lusby,MD Residence To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number **OCME JANUARY 8, 2003** Zalilla med cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple ZABILLEAH

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registra s Signature

111 Penn Street, Baltimore, Maryland 21201

			For	State of Maryla						2001	03643
			= State Registrar		Ce	ertificate d	of Death	F	Reg. No.	- 0 0 9	00040
	Physicia	an (	1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	ath Dey	Yeer	3. Time of Death
	/Medic			aul				Jan.	23	2004	3:42 pm
	Examin	er	4e. Facility Name (If not institution, give	£ 4.		4b. City, Tow	n, or Location of Dea	th		county of Deeth	
			5. Social Security Number 6. Se	ry and Mor.	s. last birthday	Becl:	ear If Under 24 Hr	S. 8 Dala of Birth	h	Raltin	
	Funeral Director		577 54 4769 15	344 005	63 Yrs.	Months Da			Year)		place (State or Foreigh
			Usual Residence of Decedent					1100 11,	1940	J   was	hington DC
	rylan how		10a. State 10b. County	10c. C	City, Town or I	Location					10d. Inside City Limits
	Ba-fa	cto	Maryland Howard		Jesst	1 <u>p</u>					1 □ Yes 2 □ No
	vith th	Directo	10e. Street and Number			10f. Zip Coo	de		10g. Citize	n of What Cou	ntry?
	s 23	ral	P.O. Box 534	12. Was Decedent Ever in	11.0 112	Was Danadant	20794	Specify Vec or No.	U	nited S	
_	Itam Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0.3.	if Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	no Rican, etc.)		Black, White,	
50	urs af	by	3 ☐ Widowed X X Divorced	1 □ Yes 2√3√No If Yes, Give 1.1 Year or Dates:		1□Yes ¾X	No Specify:		S	pecify:	White
9200-61212	filed within 72 hours after death with the Maryland Hygione. In the Market Examiner must be mailfied and.	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dec	edent's Usual Oc	ocupation one during most of we	orkina	16b. Kind	d of Business/In	dustry
N	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)	9			
2	Hygier Hygier Sther th		12		N	Mail Car		ımə (First, Middle,			L Service
300	d ta b y	Be	17. Father's Name (First, Middle, Last)  Carl E. Saul					en Reynol		umame)	
Maryland	should be filed within 72 hours after death with the Marylan not Mental Hygiene. Ind Mental Hygiene. In marked other than "natural", or Itams 23a or 28a-f show umatic avent, the Modical Examinar marked by natified at	은	19a. Informant's Name/Relationship (T)	voe Print)	19b Mai	ling Address (Str	reet and Number or F	·		Town State Zin	Code)
	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		Jean H. Crile (Si				w Wood Dri			,	
altimore,	s 1 ar		20a. Method of Disposition	20b.	Place of Disp	position (Name of ematory or other	f	Date		ation - City or To	
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2XXCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State		•	an 26. 200	1/4	Clin	iton, Ma	ryland
<u>=</u>	permit. Pages Department of Important: If I any injury or on		21. Signature of Funeral Service Licens			22. Name and Ad	dress of Facility Le	e Funeral	L HOm	e,Inc 6	63301d
מ	205 28	0 19	MUSPIT	Al 1001			ria Ferry			, Maryl	and 20735
4. 4. 45 4. 5. 5.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de- ne cause on each line.	ath. Do not e	nter the mode of	dying, such as cardia	ac or respiratory an	reșt,		Approximate Interval Between Onset and Death
	hysician	1	Immediate Cause (Final disease or condition resulting in death)	a. Myocan	die	int	archen				Bolanis
	/Medical Examiner		resulting in dealin)	Due to ( as a conse		2	ery di				J
		-	Sequentially list conditions,	b. OYZOY	Vary	art	cry al	2 ecle			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				į				
o o	e be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conse	equence of):						
	<u> </u>	cal		d							
99	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	IF FEMALE:							1	
ROX	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tai death 3	□Ectopic pregna			23	d. Date of delive Month	ery Day Year
	the a	yslc	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify	//				
J.	res that the signed by the detaction of	h h	Part II. Other significant conditions co	ntributing to death but not re	sulting in the	underlying cause	given in Part I.	23e. Did to	bacco use	contribute to t	ne cause of death?
dS	uires n sign ild be		ityper	tension				1 🗆 Y	es 2 🗆	No 3 Prot	oably 4 Unknown
Kecords,	s been si should	Completed	()					24a. Was a		24b. Were auto	psy findings available
ř	The lay te has	mo						autop: perfor		prior to co death? 1 \( \sum \text{Yes}	mpletion of cause of
		a	25. Was case referred to medical 26. Place of Death (Check only of								7
	Physic this ce al direc	To B	examiner?	Hospital: Inpatient 2	☐ ER/Outpatio	ent 3 DOA	Other: 4 Nursing	Home 5 Resid	ence 6 (	Other (Specif	y)
0	ng Pt fter th		27. Menner of Death 1 Watural 5 ☐ Pending	28a. D te of injury (Month, Day Year)	28b. Time Injury		njury at Work?	28d. Describe h	ow injury	occurred	
Division of	Attending Physician: r death. actor: After this certific by the funeral director.	catl	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No				
$\leq$	or At offer of Direct of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		street, factory, off	ice	281. Location (S City or Tow		Number or Hura	il Route Number,
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Phy	vsician: To the best of my ki	nowledge dea	ath occurred at th	e time, date and place	e and due to the o	ause(s) au	nd manner as s	tated
	24 hose Fun	edical	(Check only 2 Medical Exam	iner: On the basis of examinand manner stated.	nation and/or	investigation, in n	ny opinion, death occ	urred at the time, o	iate and p	lace, and due to	the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of vertifier			29c. Lic	ense number	2	29d. Date	signed (Month,	Dey, Year)
			* (O/H)	1 stone	1 400	D	005330	200	11	123/0	14_
()	17 -		30. Name and address of person who o	ompleted cause of death (Ite	em 23a) (Type	e, Print)			1	1	St. Baltimore
1	D3		University of	Mary and	Medici	u Cie	wtor-	22 Soi	uth (	Greene	St. moan
	Sta		31. Date filed (Month, Day Year)	114 \$2. Registrar's Sign	nature	brech					

	1/25/0	_	For State Registrar		State of N	Maryland	-		of Health of Death			iene	111	0361
			Decedent's Name (First	t, Middle, Last,	)						2. Date of Dea	h	- C.J. 1/2	3. Time of Death
	Physic /Medi		Thomas	з Ј.		Twom	еу				Month Januar	y 13 2	Year 2004	3:00p <sup>M</sup>
	Exami		4a. Fecility Name (If not in					4b. City, To	wn, or Location	of Death		4c. County	of Death	
100			Anne Arus 5. Social Security Number			Cente: Age (In yrs. las)			polis Year If Under	24 Hrs.	9 Date of Birth			rundel
Ė	Funeral Director		579-40-20	2362 15	M 2□F	78	Yrs.		ays Hours	Min.	8. Date of Birth (Month, Day) July 6		Was	place (State or Foreign ntry) hington, D
	land		Usual Residence of Dece 10a. State 10b.	County		10c. City, T	Town or L	ocation					1	10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show	to	MD Ai	nne Aru	ndel			Sh	ady Side	9				1 ☐ Yes 2 ☑ No
	or 282	Oirec	10e. Street and Number					10f. Zip Co	ode		1	0g. Citizen of W	/hat Cour	ntry?
	ath w	rai	4923 Thomas					20	764			USA		
_	be filed within 72 hours after death with the Marylan it all Hygiene.  Id other than "natural", or flems 23a or 28a-1 show avent, the Medical Examine must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 □ Widowed 4 □ □	12. Was Deceder Armed Force: 17 Yes 2 [ If Yes, Give	s? ∃No		Was Deceden If Yes, specify 1 ☐ Yes 2√2	t of Hispanic Or Cuban, Mexical No Specify:	n, Puerto P	cify Yes or No- Rican, etc.)		k, White,		
Ş	hour			ecedent's Edu	Year or Dates:			dent's Usual C				16b. Kind of Bu	wh	ite
	n na	piet	(Specify on	y highest grade	e completed)		(Give	kind of work of DO NOT use	lone durina mos	t of workin	g	160. Killa of Bu	2111622/111	dustry
7	giene. er than	Completed	Elementary/Secondary	(0-12)	College (1-4o	1 3+)	elec	trical	engine	er		General	Ele	ctric Co.
	be file tal Hy d oth d oth	Be (	17. Father's Name (First,	Middle, Last)					18. Mothe	er's Name	(First, Middle, M	faiden Sumam	ө)	
	J Men narke	မ	Richard	Nagle			[wome	4	Franc		Clevel			ennan
Ž	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/R						treet and Number					Code)
-	of Heal		Mary E. Coti		sister	20b. Place	e of Dispo	sition (Name	Lane, We			01085 Oc. Location - 0		own, State
pallillore	0 = 0		1 ☐ Burial 2 💥 Creation 5 ☐ C			(0)		natory`or othe itan Cr		01_1				
<u> </u>	permit. Pag Department Important: any injury once.		^ 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 01-15-04 Alexandria, VA  21. Signature of Fungral Service Licensee 22. Name and Address of Facility											
٥	80 = 80		Ville	m K.	The		R	ausch :	Funeral	Home	, P.A.,	Owing	s, M	D 20736
			23a. Part1. Enter the disc shock, or heart failu	ease, or compli re. List only or	ications that caus ne cause on each	ed the death. (	Do not ent	er the mode o	dying, such as	cardiac or	respiratory arre	st,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)  a. Cereboursculur Accident  Sus.											
	/Medical Examiner		resulting in death)		$\mathbf{D}$	as a consequen		AL	AR C	k'1	min	$\sim$		3444
	§.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										34-202	
	outed ansit	mi	Cause (Disease or injury that initiated events resulting in death) Last  C										124 ears	
5	ate be executed hysician and the burial-transit	Exa											1.3	
	ate by	licai		•	Cor	whou	4	BHU	Schen	200	e weu	ausa	NOR	ldyeon
3	Attending Physician: The law requires that the death certifics death. ecter: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the state of the control of the con	by Physician/Med	IF FEMALE: 23b. Was decedent pregr in the past 12 month	idili.		2 Fetal de	ath 3□	Ectopic pregr				23d. Date		nry Day Year
5	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregnant 9☐ Unknown	at time of death	7 5	Other (special	y)			141011		Day 16ai
5	that the that the that the that the the that the the the the the the the the the th	H.	Part II. Other significant of	onditions cor	tributing to death	but not resultin	ig in the u	nderlying caus	e given in Part I.		23e. Did tob	acco use contri	bute to th	e cause of death?
3	quires n sign ald be	q p	myelody?	place	iaw	ith P	and	4 top	mis		1 <u>□</u> Ye	2 00 3	3 🗌 Prob	ably 4 🗀 Unknown
necolds,	aw requires been signal 2 should to	Completed	END STAG	se tu	drey	lisers	20	m he	mudia	24519	24a. Was an		ere autor	osy findings available
	The lav	mo		J	( )					1 -	autopsy perform 1 Yes 2	ed3 de	ior to con eath? Yes	npletion of cause of
	certificate rector, pag	Be C	25. Was case referred to examiner?	medical					26. Place	of Death	Check onl one		163	42.4
	this ce al dire	P	1 ☐ Yes 2 No	Н		tient 2 🗆 ER/	Outpatien	t 3 DOA	Other: 4 🗆 Nu	rsing Home	e 5 🗆 Reside	ice 6 🗆 Other	r (Specify	)
	After 1	in oi	27. Manner of Death	Pending	28a. Date of In (Month, D	jury 281 Day Year)	b. Time of Injury		Injury at Work?		ld. Describe ho	v injury occurre	d	
	or Attendater death Director: /	Certification:	2 Accident 3 ☐ Suicide 6 ☐	Could not be	28e Place of I	njury - At home	farm etr	M factory of	1 ☐ Yes 2 ☐ I	-	M Location (Str	act and Mumba	ror Dum	l Route Number,
	after Direction by	erti	4 Homicide	determined	building,	etc. (Specify)	, 101111, 3(1	oet, factory, of	il Ce	20	City or Town,		r or Hurai	Houte Number,
	I of the thospital of Artending Priyatcian: The within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1	ertifying Phys	ician: To the bes	st of my knowled	dge, death	occurred at t	ne time, date an	d place, an	d due to the ca	use(s) and man	ner as sta	ated.
	lo the hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 N	edical Examin	ner: On the basis and manner s	of examination	and/or in	estigation, in	ny opinion, dea	th occurred	at the time, da	e and place, ar	nd due to	the cause(s)
,	vethin 2 To the comple	Σ	29b. Signature and title of	certifier					cense number			d. Date signed		
	,		Jus C	Xow	cano	S			083	14	0	11131	120	04
5+	1		30 Name and ad ress of	person who co	mpleted cause of	death (Item 23	а) (Туре, <b>) \ ]</b>	Print)	Fense	His	heans	A		Jack That
	Sta	te	31. Date filed (Month, Da)	Year)	32 Regis	trar's Signature		- 130	, , , ,	- 214		DWWD	, many	טדויסטיייןו
			1441	1 1" '201	10 E.A.	I.A	A	ALC:						

			For Stete Registrer	State of M	aryland / Depa Cei	artment of H			iene	104	03645
			Decedent's Name (First, Middle, La	st)				2. Date of Deat	h		3. Time of Death
	Physici		James	Alton	Travis		Sr.	January	Day 18	Year 2004	6:15 a M
	/Medic Examir		4a. Facility Name (If not institution, giv				r Location of Death		4c. County		0.13 a
			Calvert Memorial	Hospital		Prince	Frederick		Calve	art	
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	je (În yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthpla	ace (State or Foreign
	Director		214-10-3043	M 2□F	81 Yrs.	Months Days	Hours Min.	(Month, Day, Dec 15,	1922	Virgi	
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					-	
	sho	ក			700. Oily, 10 Wil Gi Ed					10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	MD Calver	C	<u> </u>		ince Fred				
	with page of					10f. Zip Code		110	og. Citizen of V	what Count	ry?
	eath	era	5890 Ketch Road  11. Marital Status	12. Was Decedent	Ever in U.S. 13.1		678 Visnanio Origina /Sr	nocity Voc or No	USZ	e - America	n Indian
<b>'</b> O	r Iten	by Funerai	1 Never Married 2 Married	Armed Forces? 11☑ Yes 2 ☐ I	No I	f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White, e	
ဗ္ဗ	ours a	ò	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify	⁄: wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther then "natural", or Items 23a or 28a-f show ont, Its Medical Exertice must be rediffed at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Deced	dent's Usual Occup	ation during most of work	1	6b. Kind of Bu	usiness/Indu	ustry
7	ithin	пр	Elementary/Secondary (0-12)	College (1-4or 5	life. I	DO NOT use retired	d)	ang			
7	ygier th	ပ်	12		elect	rician, e	electrica				struction
ב	e data b	Be	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle, M	fa <i>iden Sum</i> am	10)	
$\frac{8}{5}$	should be ind Mental s marked umatic ev	٦°	Aaron James	Travis			Nina				nomas
	12 st hand 7 Is n traun		19a. Informant's Name/Relationship (				and Number or Rur		City or Town,	State, Zip C	Code)
ص 	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Tracey T. Long, 20a. Method of Disposition	daughter	2687 () 20b. Place of Dispo	. County	Rd. 98,		A 9561 Oc. Location -		m State
5	ages nt of t: # it		1 Burial 2X Cremation 3	Removal from State	cemetery, cren	natory`or other plac	e)			•	
altimore,	artme orten injur		<ul> <li>4 □ Donation 5 □ Other (Specifical Service Liceration)</li> <li>21. Signature of Euneral Service Liceration</li> </ul>		Metropoli	. Name and Addres		20-04 <i>I</i>	Alexand	dria,	VA
ä	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		> Wolcam R	2	_		•	o D 7	0-3	\	20726
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do not ente		neral Home g, such as cardiac			,	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	6.4.							nterval Between Onset and Death
	/Medical		disease or condition resulting in death)		tatic CC	incer L	F Head	a Ne	2CK	m	ore than Lya
	Examiner			b	, , , , , , , , , , , , , , , , , , , ,						
	n =	ner	Sequentially list conditions, 2, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,		a consequence of):						
	outed nd transi	Examiner	that initiated events	C							
Ö,	e exe		resulting in death) Last	Due to (or as	a consequence of):						
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		_ d.						-	
9 ×	ding p	Me	IF FEMALE:	23c. If yes, outcome	of programs.						
Вох	eath certifi attending p	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date Mor	e of delivery oth D	/ Day Year
o.	at the de by the a stached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	time or death 5	Other (specify)					
ح َ	that ted by deta		Part II. Other significent conditions of	ontributing to death b	ut not resulting in the un	nderlying cause give	en in Part I.	23e. Did toba	acco use contri	ibute to the	cause of death?
Records,	w requires that s been signed t should be det	Completed by	Prostate C	oncer.				1 ☐ Yes	2 □ No	3 Probab	oly 4 Dunknown
ខ្ល	w rec	lete	Gastra aconh	age cul R	effux d	isease		24a. Was an	24h. W	Vere autons	y findings available
2	: The law cate has page 2:	mo	0 93110 ESU/11	igo ca	Cheek a	Bease		autopsy performe	ed? d	rior to comp eath? Yes 2	y findings available pletion of cause of
		a	25. Was case referred to medical				26 Place of Death	1 ☐ Yes 2 ☐ 1 Check onlone		□ Yes 2	∐ No
<u> </u>	Physici this cer al direc	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [1]Inpatie	nt 2 ☐ ER/Outpatient	t 3□ DOA Othe	VC	me 5 Residen	- 15	or (Specify)	
0	iding Ph th. After th funeral	T: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28c. Injury Work	at	28d. Describe how			
Division of	Attendir death. ctor: Al y the fu	atic	2 Accident investigation	1	,,		res 2 □ No				
Ĕ	after deati	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural F	Route Number,
_ ;	spitel or ours aft nerel Dil filled in										
;	Hospitel or Attending Physicien: 44 hours after death. Funenel Director: After this certific tely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	niner: On the basis of	of my knowledge, death examination and/or inv	occurred at the time estigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, date	ise(s) and mar e and place, a	nner as state nd due to th	ed. ne cause(s)
,	To the Hospitel within 24 hours a To the Funerel C completely filled in	Mec	29b. Signature and title of certifier	and manner sta	meu.	29c. License	number	290	d. Date signed	(Month Da	v. Year)
	⊢ ≱ ⊢ ŏ		Lyan	C. 1	Surana	$\mathcal{T}$	50653		1-18		
		-	30. Name and address of person who	completed cause of d	eath (Item 23a) (Tuno 5	Print)	AN .C		•		
10	>+\		mari n	001		Road	Dea		RANK D	205	751
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	1000	Vacu	10 111	<i></i>	(	
	Registra	ar	JAN 2 0 2004	Re.	4 / 00	2					

			1- For State of Maryla	nd / Depa		lealth and M	lental Hyg	iene <sub>ea. No.</sub> 2004	03646
			Decedent's Name (First, Middle, Last)		Timouto or	- Douin	2. Date of Dea	eg. 140.	3, Time of Death
	Physici	an	-	lman			January	Day Year	6:25 A M
	/Medic		4a. Facility Name (If not institution, give street and number)	1111011	dh Cihi Tourn	or Location of Death	Darraary	4c. County of Deat	
	Examin	er					1-		
			Calvert Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	If Under 1 Year	Frederic  If Under 24 Hrs.		Calvert	
	Funeral Director		523-28-3309 1□M 2XF 90	• •	Months Days	Hours Min.	8. Date of Birth (Month, Day) Oct. 13	1913 Kar	hplace (State or Foreign untry) 1Sas
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Aaryl Feho	٥	MD Calvert	Solom					1 ☐ Yes 2 ☐ No
	1he N	ect	10e. Street and Number		10f. Zip Code			0-04	
	with	<b>Funeral Director</b>	13325 Dowell Road		206	388		-	•
	eath	era	11. Marital Status 12. Was Decedent Ever in	11.5			neity Van av Na		
	ter d	Ë	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	0.3.	If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
36	rs at	by F	3 ★ Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specify: Wh	ite
21215-0036	tiled within 72 hours atter death with the Maryland Hybione. Ither then "neturel", or Items 23a or 28a-f ehow int, the Medical Evaniner must be notified at	ed	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation		16h Kind of Business/	Industry
5	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retire	during most of worki d)	ing	TOD. INITIO OF Educations of	industry
7	with ene.	шo	Elementary/Secondary (0-12) College (1-4or 5+)  12 -		emaker	,		Own Home	
0	tiled Hyg other	C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M		
Maryland	2 should be tiled within 72 hours after death with the Marylan and Manhal Hygiens. I and Manhal Hygiens is marked of the titlen "neturel", or items 23a or 28a-1 ehow aumatic event, the Medical Examiner must be notified at	To Be	Charles Bittner			Mary S	charman		
<u> </u>	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Street			City or Town State 7	in Code)
Š	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Ie markad any injury or other traumatic ev once.		Dorothy J. Underwood (DAUGHTE						
ā,	Hea Hea tem				sition (Name of matory or other place		TALL TO THE PARTY OF THE PARTY		
ᅙ	ages nt of nt of t: M is		I Bullar 2 Cremation 3 Linemovaritom State						
Baltimore,	it. P trtme trten prien		* 4 □ Donation 5 □ Other (Specify)  21. Signatur of Junera Terryce/Ligns e	tropoti	tan Crem	atory Jan	.19,2004	Alexandri	a, VA
Ba	Depa Impo any i		11/11/11/11						
		1 (1	MO 10						·
			23a. Part1. Enter the dispase, of complications that caused the designock, or heart landre. List only one cause on each line.	Itti. Do not ent	er the mode of dylr	ng, such as cardiac d	or respiratory arre	est,	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a conse	pulu	ONARY	ARRE	57		Shoot and Boam
	/Medical Examiner					١.			
		_	Sequentially list conditions, b. CEREBR		CULAR	DISEF	15E		
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	quence ot):					87 Tampa, FL 33613 c. Location - City or Town, State  Alexandria, VA eral Home, P.A. c. Republic, MD 20676
	and -tran	кап	that initiated events resulting in death) Last  C.  Due to (or as a conse	augus of):					
/60,	be executed sician and burial-transit		Due to (of as a conse	querice or).					
20	physicate by the b	dicai	d						
×	leath certitic attending p	/Me	IF FEMALE:						
Rox	ath c	ian	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fell in the past 12 months?	tel death 3	Ectopic pregnancy	1			
o.	at the de by the a tached t	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	death 5∟	Other (specify)				,
<u>.</u>	hat the deby detac	P.	Part II. Other significant conditions contributing to death but not re	eulting in the u	adartuina cauca an	ron in Part I	23a Did tob	acco use contribute to	the equen of death?
ecords,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by	ALZHEIMER'S DEMEN		idenying cause giv	en ar arti.		s 2 □ No 3 □ Pro	
Ö	w require been sig should b	etec		J 11-7					
ည္	alaw hast e2s	npi	_ ANEMIA				24a. Was ar autopsy	prior to co	opsy findings available ompletion of cause of
		S					perform 1 Tes 2		2 No
=======================================	Physicien: this certitic: ral director,	Be	25. Was case referred to medical examiper?			26. Place of Death	(Check only one	9)	
6	a this	2		ER/Outpatien		4   Nursing Hor		nce 6 Other (Speci	ify)
_	ng the ng	Certification:	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	w injury occurred	
<u> </u>	Attending ir death. ector: Atter by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No			
DIVISION	or At Iter d iirect n by	E	4 Homicide determined 28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	eet, factory, office	2	28f. Location (Str City or Town,	eet and Number or Rur . State)	al Route Number,
_	urs a					4			
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.	owledge, death ation and/or inv	occurred at the tire restigation, in my o	ne, date and place, a pinion, death occurre	ind due to the ca ed at the time, da	use(s) and manner as a te and place, and due t	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
	- s - o		· Oliver Johnso	n	D5	8385			
	. 1		30. Name and address of person who completed cause of death (Ite	m 23a) /7:				Jan. 18, 20	JU4
	6					Davis	1	MD 000550	
	Sta	te.	Olivia Johnson, M.D. 110 Hosp 31. Date filed (Month, Day, Year) 32. Registr S Sign	antura.			euerick	, YUU 206/8	
	Registr		JAN 2 0 204 > See	as K	Gorde				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 26, Day 2004 **Physician** MARY BESSTE THOMAS 1:30 A /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street and number) Examiner CHARLES NEWBURG 12560 SHILOH CHURCH ROAD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 19, 1929 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 F MARYLAND 75 Director 579-42-3767 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event. The Modical Examinational be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No NEWBURG CHARLES Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20664 12560 SHILOH CHURCH ROAD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: BLACK Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be REBECCA ANN GREEN FRANCIS GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 MIDILOTHIAN PLACE, WALDORF, MD 20602 MARY P. CHERRY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 3 Removal from State SHILOH UNITED METH CH. CEM/01/30/2004 NEWBURG, MARYLAND 22 THORNION FINE TO HOME PA 34.39 LIVINGSION KOAD, INDIAN HEAD, MD 20640 21. Signature of Funeral Service Censee LYDIA C. THORNION JOHNSON MO0583 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA BRONCHOGENIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (brias a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To Pis 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of defifier 29c. License number D53885 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VENICAT. S. KAMANAN 50 POST OFFICE ROAD #101 WALDURF

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

JAN 29

32. Registrar's Signature

			For State Registrar		State of	Marylan				lealth a	and M		Reg. No.	004	03648
	Physici	an	1. Decedent's Name (First, Mid	dle, Last)								2. Date of De. Month	Day	Year	3. Time of Death
	/Medic		<u>Lester</u>		ton	Varne	У,	Sr.				Januar		2004	2:28 p M
	Examin	er	4a. Facility Name (If not instituti	_		_		1		Location o				ty of Death	
			Calvert Memor  5. Social Security Number	ial 6. Sex		Age (In yrs.	last hirthday		Princer 1 Year	e Fre		8. Date of Birt	h	Calve 9. Birth	ert place (State or Foreign
	Funeral Director		235–62–6967		M 2 F	63	Yrs.	Months		Hours	Min.	(Month, Da Dec 20	y, Year)	Coul	Virginia
			Usual Residence of Decedent									DCC 20	1310		
	how		10a. State 10b. Coun	ty		10c. Cit	y, Town or L	ocation.						1	10d. Inside City Limits
	aa-fa	cto	MD	Cal	vert					Hunt	ingt	own			1 ☐ Yes 2 ☑ No
	or 2	Director	10e. Street and Number					10f. Z	ip Code		_		10g. Citizen of		ntry?
	death with the Maryland ms 23a or 28a-f show firtual be notified at		5571 Stephen F		Road 12. Was Decede	not Ever in III	S 13	Was Dec	edent of H	20639		acify Yes or No		USA Ice - Americ	can Indian
	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f shown, the Madrial Examiner must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 ☑ Ma		Armed Force	es?	.5.			n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	Bla	ack, White,	
S	urs af	þ	3 ☐ Widowed 4 ☐ Divorce		If Yes, Give Year or Date		į	1 🗋 Yes	2 <b>X</b> No	Specify:			Spec	ity: wh	nite
213-0030	within 72 hours after ene. than "natural", or Ite he Modical Externine	Completed	15. Decede (Specify only high	ent's Educ	cation		16a. Dec	edent's Us	ual Occup	ation during mos	t of work	ina	16b. Kind of	Business/In	idustry
Ž	thin 7	nple	Elementary/Secondary (0-12	1	College (1-4	or 5+)	life.	DO NOT	use retired	1)		9	The Sheet	7 De	1. Coursi co
V	e filed wi	S	12				ree	der t	ruck	drive		(Since Mindelle			el Service
yiand	be fill hall H bd ott	Be	17. Father's Name (First, Middle	e, Last)								e (First, Middle,	Maiden Suma		
2	2 should be and Mental Is marked raumatic ev	L <sub>0</sub>	Floyd  19a. Informant's Name/Relation	achia (Tu	na Printl	Var	ney	lina Addra	ec /Street		Merr	1 III al Route Numbe	or City or Town		ens
Z	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic											d, Hunt			20639
ย์	es 1 and 2 of Health a f Item 27 ls r other tra		Judi Carol Va 20a. Method of Disposition	irney	, wife	20b. P	lace of Disc	osition (N	ame of	- 1		Date	20c. Location		
2	ages int of t: If It		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from Sta	are	emetery, cre			ŧ	Ω1 .	22-04	Godby	Hoimh	te Wi
Saitimor	permit. Pages. Department of t Important: If It any injury or of once.		21. Signature of Funeral Service		91	ПТ			-	ss of Facilit		22-04	GCCLDy	петдп	ics, w
0	Dep Imp		William	RA				kaus	ch F	nera.	1 Ho	ne, P.A	., Owi	ngs,	MD 20736
,00/90	Playsician and hysician and hysician and hysician and hysician signal in partial in part	Ical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	st only or	Due to (or	ente Pu as a conseq as a conseq as a conseq	uence of):								Interval Between Onset and Death
r.C. box od	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnan 9□ Unknow	h 2 ∏ Feta nt at time of d n	I death 3 eath 5	Other (				23a Did to	М	ate of deliver	ery Day Year he cause of death?
'n	igned be d	by	Non Hodgkins		_	th but not res	ulting in the	underlying	cause give	en in Part I.	•				pably 4 Unknown
ecorus,	requi	eted	NOIT HOUGKITS	יוענים כ	iprona							· · ·			
	The lay ate has page 2	Completed												prior to co death?	opsy findings available impletion of cause of
VII	ysician: Th is certificate director, pag	Be	25. Was case referred to medie examiner?		lospital:				Oth	OF:		(Check only a			
0	ding Phys h. After this funeral di	tion; To	1 X Yes 2 No  27. Manner of Death 1 X Naturat 5 □ Pend		28a. Date of (Month,		28b. Time Injury		28c. Injun Worl	4 🗆 140		me 5 🗌 Resid 28d. Describe h			(y)
DIVISION	dea dea ctor	Certification	3 Suicide 6 □ Coul		28e. Place of building	Injury - At ho , etc. <i>(Specif</i>	ome, farm, s	treet, facto	ory, office			28f. Location (S City or Tov		ber or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical (			sician: To the base ner: On the base and manne	is of examina									
	To the within To the comp	Me	29b. Signature and title of certr	tier	1	50			9c. License				29d. Date sign	ed (Month,	Day, Year)
				(	-			] ]	331	23			Jan. 1	6, 20	004
			30. Name and address of person	on who co	mpleted cause										
	10		Jonathan Low		al, M.D.	, 110	) Hosp	ital	Rd.,	Ste	310,	Pr. Fr	ed., MI	206	578
	Sta Registi	_	JAN 2 0 200		32. Reg	gistrar's Signa	ocies .	,							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of	Maryland	•	rtment of F tificate of		d Mental H	ygiene Reg. No.	2004	03649
	Physicia /Medic	an al		HY SAR	AH WE					2. Date of D Month	23	Year 64	3. Time of Death 4:30 PM
	Examin		4a. Facility Name (If no Atlantic					4b. City, Town, o Berlin		Death		ounty of Death	
	Funeral Director		5. Social Security Num 154-05-12	6. Se		7. Age (In yrs. I. 85	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, L 9/14)		9. Birth Cou	place (State or Foreign intry) N J
	h the Maryland rr 28a-f show	o.	Usual Residence of De 10a. State 19	Ob. County  Worces	ter	10c. City	, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
	with the M sa or 28a-f	i Director	10e. Street and Number					10f. Zip Code 218	11			en of What Cou	intry?
936	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show nit, the Madical Examiner: sust be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 [		12, Was Deced Armed Ford 1  Yes 2 If Yes, Give Year or Da	•	S. 13. V	Vas Decedent of H Yes, specify Cub		? (Specify Yes or Nuerto Rican, etc.)	10- 14	Race - Ameri Black, White Specify: Wh	, etc.
Maryland 21215-0036	Jwithin 72 hou jiene. Ir than "nature Ire Medical E	Completed	(Specify Elementary/Seconds 12	5. Decedent's Edi only highest grad ary (0-12)	cation le completed) College (1-	4or 5+)	(Give life. L	ent's Usual Occup kind of work done OO NOT use retire memaker	oation during most o d)	f working		of Business/Ir	
and 2	a la b	To Be Co	17. Father's Name (Fin	rst, Middle, Last) nd Wilso	n			, ,		Name (First, Midd ttie Bord		iumame)	
Maryi	s 1 and 2 should I Health and Men Item 27 Is marke other treumatic	F	19a. Informant's Nam Frances	e/Relationship (T			1	•		Berlin, M		Town, State, Zi	ip Code)
Baltimore,	Pages ment of ent: If i		20a. Method of Dispos 1  Burial 2  6 4  Donation 5	Cremation 3 ☐ XOther (Sped	htombm	iate	ranite	sition (Name of natory or other pla Memorial . Name and Addre	s 1	Date / 26 / 04	Bis	shopvill	le, MD
Ba	permit. Departimental		23a, Part1. Enter the	sich Bu	tale_	wand the deet				Burbage Berlin, M		ral Hor	<b>ne</b> Approximate
30	Pnysician /Medical Examiner	ner	shock, or heart Immediate Cause (Findisease or condition resulting in death)  Sequentially list cond if any, leading to many cause. Enter Underly Cause (Disease on in)	failure. List only on al	a. Cro	ich line.	uence of):		200	dont			Intérval Between Onset and Death 5
1918 12004 16 18760,	wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Cause (Disease or inj that initiated events resulting in death) Las		c	or as a conseq	uence of):						
ab 9/14, b 1/23/ O. Box 6	the death certifi y the attending i ached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 ⊡f 9 □ Unknown	optis?		inth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pregnanc Other (specify)	У		23	3d. Date of delin Month	very Day Year
ds, P.	law requires that the as been signed by th 2 should be detach		Part II. Other significa	ant conditions co	ontributing to de	ath but not res	ulting in the u	nderlying cause gr	ven in Part I.				the cause of death?
We//5	2 35 8	Completed								pe	as an topsy rformed? ; 2⊟No	prior to c death?	topsy findings available ompletion of cause of 2 No
√ co Vital	Physicien: The lav this certificate has ral director, page 2	Be	25. Was case referred examiner?	_	Hospital:	npatient 2	ER/Outpatier	ot 3 DOA Ot		f Death (Check onling Home 5 ☐ Re		Other (Spec	ify)
154-154-	ding Phys h. After this funeral di	ion; To	27. Manner of Death 1 Natural	5 Pending	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time o Injury	28c. Inju		28d. Describ			,,
Don. 15 Division	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place	of Injury - At he	ome, farm, str y)	eet, factory, office		28f. Location	(Street and Town, State)	Number or Ru	ral Route Number,
	e Hospite 724 hours le Funeref letely filled	edical C	29a. Certifier 1 (Check only 2 one)	Certifying Ph	niner: On the ba	best of my kno asis of examina ner stated.	owledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	ne cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and tit	tle of certifier	msici	1)	A.O.	29c. Licen	se number 4283		29d. Date	signed (Month	n. Day, Year)
3	7 4		30. Name and addres	ss of person who	DUPIC.	2 9	733	Print) Hez/	Muzi	g Drew	-	Bere	le_, "1811
	St Regist	ate rar	31. Date filed (Month		2004 32. 7	gistrar's Signa	d A	parte					

			ricase i		Maryland /						-		_		ette ett om enne
			1 - For State Registrar	Olate of I	viai y laria i		rtificate					g. No.	ZUU		03650
	• 10		Decedent's Name (First, Middle, Last)								2. Date of Deat	h _		1 -	. Time of Death
	Physici		Myrtle Lou	ise	Worley						January	9,	2004	ar	5:00 pм
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and numbe	er)		4b. City,	Town, or	Location	of Death		4c. (	County of D	eath	
			Millennium Health 8					ewate					ne Ar		
	Funeral		5. Social Security Number 6. Sex	M 2 <b>X</b> F 7.	Age (In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day,	Year)	9.1	Birthplace Country)	e (State or Foreign
	Director		Usual Residence of Decedent		88						Oct. 16,	, 191	5   V	irgi	ша
	/land		10a. State 10b. County		10c. City, Tov	wn or Lo	cation							1	Inside City Limits
	Man a-f sh	tor	Maryland Anne Arur	ndel	Edgew	ate:	r								1 ☐ Yes 2 ☐ No
	or 28	)ire	10e. Street and Number				10f. Zip				10		en of What	•	?
	ath w	rai	144 Washington Roa					1037				-	U.S.A		
	er des	une	T. Hartar States	2. Was Decede Armed Force	s?	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - A Black, W		
36	rs aft	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ( If Yes, Give Year or Date			1 ☐ Yes 2	2 <b>⊠</b> No	Specify:				Specity:	wh	nite
21215-0036	filed within 72 hours atter death with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-f show int, the Medical Examinat hust be notified at	ted	15. Decedent's Educ	ation	168	a. Dece	dent's Usua	Occupa	ition	a ná umaki		l 6b. Kin	d of Busine	ss/Indust	try
215	e. en "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	kind of wor DO NOT us	e retired,	)	i or works			17 61	_	
	ygien ygien t. Ee	Completed	8			Man	ager						il Sh	oe S	tore
nd	be fill d oth	Be	17. Father's Name (First, Middle, Last)							ers Name annie	(First, Middle, N	ochr			
Maryland	should ind Men s marke umatic	٦	John Hash  19a. Informant's Name/Relationship (Ty)	an Print)	10	h Maili	a Address	(Street s			i Route Number,			a Zin Coo	de)
Na	d 2 st th and t7 is r traur		Lenora E. Hankins,	•							Huntingt				
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Place	of Dispo		ne of					ation - City		
m <sub>o</sub> m	Pages ent of nt: If i		1 ☐ Burial 2 XCremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	ite					Jan	.14,2004	Al	exand	ria.	VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet mast be notified at any injury or other traumatic event, the Medical Examinet mast be notified at another.		21. Signature of Funeral Service License	6 (		-	. Name an				14H 23				
Ö	Department of the permanent of the perma		Daya -	[ ] es	back	R	ausch	Fun	eral	Home	, P.A.,	Owi	ngs,	MD 2	0736
			23a. Pert1. Enter the as ase, or complishock, or heart failure. List only on	e cause on each	sed the death. Do h line.	not ent	er the mode	e of dying	g, such as	cardiac d	or respiratory arre	st,		Ap	proximate erval Between iset and Death
	Physician		Immediate Cause (Final disease or condition	Cardio	ac Arr	hut	hmi'c	à							minutes
	/Medical Examiner		resulting in death)		as a consequence	of):					1.			1 "	ire than
M)	- Administra	<u>_</u>	Sequentially list conditions,		70501e10		arc	liac	1asci	1/02	- disec	250		5	415.
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (5.	au a 5511554251155	, 0.,.									
Ċ,	sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or	as a consequence	of):									
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	cai													
89	death certificate I attending physical for use as the t	Physician/Medi	IF FEMALE:												
Вох	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?	1 Live birth	me of pregnancy 2 Fetal deat		Ectopic pro					23	3d. Date of of Month	delivery Day	y Year
0	the a	ysic	1 ☐ Yes 2 MNo 9 ☐ Unknown	4∐Pregnant 9☐ Unknowr	t at time of death	5 L	Other (sp	ecify)							
Δ.	that the death cer ed by the attendir detached for use	Ph.	Part II. Other significant conditions con	tributing to deat	h but not resulting	in the u	nderlying ca	ause give	n in Part I		23e. Did tob	acco us	e contribute	to the ca	ause of death?
gp	uires thai n signed l	d b	Advance Eno	Stag	e der	ner	Ha.				1 ☐ Ye	s 2 🗆	No 3□	Probably	4 Unknown
O	w requir s been si should	iete	Humathumidic	m							24a. Was ar	1	24b. Were	autopsy	findings available
of Vital Records,	The la	Completed by	Lebt Bund	10 8	ronch		13100	12			autops perform 1 X Yes 2	ed?	death	?	etion of cause of No
ita	ian: rtifica	Be C	25. Was case reterred to medical examiner?	<u> </u>	101/01		1000	-	26. Place	of Death	(Check only one				
) _	Physician: r this certificatel director.	ToE	1 Yes 2 No		atient 2 ER/C				4 10 110		me 5 🗆 Reside			pecify)	
n c	ing P		27. Manner of Death 1   Matural 5 □ Pending	28a. Date of I (Month,	njury 28b. <i>Day Year)</i>	Time o Injury		8c. Injury Work			28d. Describe ho	w injury	occurred		
Sio	ttend death tor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be	29a Place of	Injury - At home, f	arm et	M (actor		res 2□		28f. Location (Str	eet and	Nuraher or	Rural Ro	oute Number
Division	or A after Direct In by	Certification:	4 Homicide determined	building,	etc. (Specify)	ariii, sii	oot, ractory	, once			City or Town			710741710	obto (VBINIDO),
_	spita tours neral		29a. Certifier 1 Certifying Phys												
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examination)		s of examination a										
	To the To the Comp	ž	29b. Signature and title of certifier		, 6			License					signed (Mo		
			) eigh		- ( W	a	v can D	506	53			Janu	ary 9	, 20	U4
	2		30. Name and address of person who co												
	a co		Gyan C. Surana, M. 31. Date filed (Month, Day, Year)	5851	Deale Ch	urc	nton I	Rd.,	Deal	e, M	D 20751				
	Sta Registi		JAN 1	4 2009	istras Signature	K	400	ALL P							

			State of Maryland / Department of Health an Certificate of Death		piene 2004 03651
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)  (Articles)  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Control of Contr		th Day Year 3. Time of Death 7755 M  4c. County of Peath
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  10 M 2 F  10 M 2 F  11 M 2 F  12 Th I A C  14 Under 1 Year If Under 24 Hours  15 Usual Residence of Decedent	4 Hrs. 8. Date of Birth Min. (Month, Day	(Year) 9. Birthplace (State or Foreign Country) 12,1942 Virginia
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show the Modeal Examinat must be modified at	Director	10a. State     10b. County     10c. City, Town or Location       Maryland     Anne Arundel     Lothian       10e. Street and Number     10f. Zip Code	1	10d. Inside City Limits 1 □ Yes 2 ☑ No  10g. Citizen of What Country?
920	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 XDivorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:  1 Yes 2 No If Yes 2 No I	n? (Specify Yes or No- Puerto Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	filed within 72 ho Hygiene. other than "natur ent, Ine Wooles	Completed		of working	16b. Kind of Business/Industry  Self employed  Maiden Sumane)
Maryland	12 should be f h and Mental h 7 Is marked of traumatic even	To Be		issa Mar	ie Stallard r, City or Town, State, Zip Code)
a,	t. Page rtment o rtant: If njury or		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Geo. Washington Universi	Date	20c. Location - City or Town, State
Ba	Depar Depar Impo any ir		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	<u> </u>	Owings, MD 20736  Approximate Interval Between Onset and Death
8760,	death certificate be executed  A granding physician and included in the purial-transit included in the purial-transit included in the purial included in the purial included in the purial included in the purial pu	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Lue to (or as a consequence of).  Chrowic Obstructive Pull of the consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	movary	
O. Box 6	that the death certifice led by the attending ph detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown		23d. Date of delivery Month Day Year
cords, P.	v requires been sign should be			23e. Did tol	
Vital Re	Physician: The lav this certificate has ral director, page 2 a	Be Completed	25. Was case referred to medical examiner?	autops perform  1  Yes  of Death (Check only on	prior to completion of cause of death?  AQNo 1 ☐ Yes 2 ☐ No
Division of Vital Record	ttending Phys death. ctor: After this of the funeral dir	Certification: To	1   Inpatient 2   EH/Outpatient 3   DOA 4   Nursi	28d. Lescribe ho	once 6 ☐Other (Specify)  winjury occurred  treet and Number or Rural Route Number,
Div	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certif		City or Town	n, State) ause(s) and manner as stated.
•	To the within 2 To the complet	Med	and manner stated.  29b. Signature and title of certifier  Dout of Door Double	54 2	9d. Date signed (Month, Day, Year)
	A Sta		30/Name and address of person who completed cause of death (Item 23a) (Type, Print)  William P. Joues MD (a 45 Americ  31. Date filed (Month, Day, Year)  32. Registras Signature	CA. Ct.	21035
	Regist	ar	JAN 1 4 200 & Blown & Spartis		

			For State Registrar	State of Ma	aryland		artmen tificate					jiene eg. No. 2	004	036	52
	Physicia		1. Decedent's Name (First, Middle, L Bettie	·	lood						2. Date of Dea Januar		2004	3. Time of Do	
	/Medic Examin	_	4a. Fecility Name (If not institution, git Calvert Memor		tal				Fre		ck	4c. Co	unty of Death alver	t	
	Funeral Director			Sex 7. Agr 1 ☐ M 2 ☐ XF	9 (In yrs. Ias 78	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Mar. 21	Year) , 192	9. Birthp Coun 5Wash:	ace (State or F try) ington	oreign D. (
	aryland show	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo		10.00					1	0d. Inside City	
	death with the Maryland ms 23a or 28a-f show rmust be rediffed at	Directo	10e. Street and Number	vert		Lu	5 b y 10f. Zip				1		of What Coun		X.
_	ier death with the Marylar Items 23a or 28a-f show iner must be rollfied at	Funeral	11.25 White  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 241	Ever in U.S.				spanic Ori n, Mexicar		cify Yes or No- Rican, etc.)	14.	SA Race - Americ Black, White,	etc.	
21215-0036	within 72 hours after ens. then "natural", or Ite	þ	3 M Widowed 4 □ Divorced  15. Decedent's I (Specify only highest g	If Yes, Give Year or Dates:		16a Deced	1 ☐ Yes	I Occupa	Specify:		na		ec <i>ity:</i> Wh:		
N		Completed	Elementary/Secondary (0-12) 1 2	College (1-4or 5	i+)		kind of wor DO NOT us nage	r					te Go	vernme	nt
Maryland	ould be filed Mental Hyg arked other atic event,	To Be		erick Ha	rdin				Be	rtha		На	usman		
, Mar	s 1 and 2 shou f Health and M item 27 is mar other treumati		19a. Informant's Name/Relationship Gary R. Wood/S			P.0	. Bo	x 19	00	Pri	nce Fr	eder	ick, N	1D 206	78
Baltimore,	nit. Pages 1 artment of He ortent: if iter injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec	rify)		ce of Dispo netery, crer rop.	Cre	nato	ry 1	1/7/	2004 A	lexa	ion - City or To ndria	VA	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lic	Savell		1.	451	Dare	es Be	each	well F Rd.Pr	ince	al Hor Fred	, MD 2	0678
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	y one cause in each li a. Chroi Due to (or as	ne. 11C e conseque	My inga oto: T	elo	ger	cou	s L	euk r euk r	emi	a	Approximate Interval Betwe Onset and De	
	cate be executed physician and the burial-transit	dicai Examiner	Securitary fet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diak Due to (or as ACU	a conseque	251	Me	llit	us	<b>)</b>	vosi.				
.O. Box 6	Attending Physicien: The law requires that the death certifica rideath. cetor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	leath 3	Ectopic pr Other (sp					23d	. Date of delive Month	ry Day Ye	ar
rds, P	w requires fhat been signed b should be deta	b	Part II. Other significant conditions Atheroscle	contributing to death b								-	contribute to the		
al Records,	ı: The law requ icate has been r. page 2 shouk	Completed	J. J.	lism					-			med? 2.No	death?	psy findings av npletion of cau 2 No	ailable ise of
of Vit	Physicier this certif al directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 1 Inpatie		R/Outpatier	THE PERSON NAMED IN	_	or: 4□ No	rsing Hor	n (Check only or me 5 ☐ Resid 28d. Describe h	ence 6		')	
Division of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director. page	27. Manner of Death  1 Matural  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury at Work?  1 Ves 2 No  28d. Describe how injury oc Work?  1 Ves 2 No  28d. Describe how injury oc Work?  1 Ves 2 No  28d. Describe how injury oc Work?							courred		ər,				
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical Co	29a. Certifier 12 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner st	f examination	ledge, deat	h occurred vestigation	at the tim	e, date ar pinion, dea	nd place, a	and due to the co	ause(s) and date and pla	d manner as st ace, and due to	ated. the cause(s)	
ļ	To the within 2 To the complet	Me	29b. Signature and title of certifier	flance				: License	- ^ 6	7 2		1/6	igned (Month,		
	10		30. Name and address of person what the same address of person what the same address of person which the same address of	6 completed cause of completed Suit	leath (Item 2	23a) (Type,	Print)	o Fr	edui	ck.	MDZ	067	8		
	Sta Regist		31. Date filed (Month, Day, Year) JAN	6 cympleted cause of coach Such 32. Registr	s Signatu	J.	Gre	de)		/		-			

	Robert 1 04-0021		vis Walker Pleas			delible Ink. Ensure				
F	RJ		1 - For State Registrar	State of Maryla		artment of Health an rtificate of Death	іо мептаї н	reg. No. 200	4 0365	
	Physic /Medi		1. Decedent's Name (First, Middle, Robert Lewis Walk	Last) Er			2. Date of D Month Janua	Day Year	3. Time of Death	
7	Exami	ner	4a. Facility Name (If not institution,			4b. City, Town, or Location of C	Death	4c. County of De		
			5150 Running 5. Social Security Number 6		rs. last birthday)	Hughesville If Under 1 Year   If Under 24	Hre la Data de	Charle		
	Funeral Director		214 50 9990 Usual Residence of Decedent	152 M 2□F 54	Yrs.		Hrs. 8. Date of B (Month, D Sept. 1	6 1949 Mary	rthplace (State or Foreigr country) yland	
	e Maryland a-f show	ctor	10a. State Maryland Calvert	10c.	City, Town or Lo Part Rep	ocation public			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1325 Grays Road			10f. Zip Code 20676		10g. Citizen of What C United State		
21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28a-f show dical Exarcine must be notified at	d by Fune	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)			
<u>7</u>	"natu	ete	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business	/Industry	
212	filed within Hygiene. ther than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ct scheduler		power plant n	maintance	
Maryland	e da la se	To Be C	17. Father's Name (First, Middle, La George Leonard Wall	•			Name (First, Middle y Louise In	gle		
	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship Robert L. Walker, Jr		19b. Mailir P.O. B	ng Address (Street and Number of	r Rural Route Numb st Virginia	per, City or Town, State, 25432	Zip Code)	
Baltimore,	Se do l	20a. Method of Disposition  1								
Balti	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Lice	00	440	Name and Address of Facility 1	art Republi	c, MD 20676		
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ry one cause on each line.		er the mode of dying, such as card- Carcliv Vascul			Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a cons						
, N	executed in and ial-transit	Examiner	Securation, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cons	equence of):					
68760,	ate be nysicia he bur	ledicai Exa	resulting in death) Last	Due to (or as a cons	equence of):					
.O. Box	death certifi e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of dei Month	livery Day Year	
ords, P	sign d be	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
al Record		Completed					24a. Was auto perfo	ormed? prior to death?	utopsy findings available completion of cause of	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				Death (Check only o			
vision of \	ding Phys h. After this funeral dii	tification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	Other: 4 Nursing  28c. Injury at Work?  M 1 Yes 2 No		dence 6 ther (Spechow injury occurred	city) At scene	
Vis	er deat	tific	3 Suicide 6 Could not 4 Homicide determine		home, farm, stre		28f. Location (	Street and Number or Ru	ıral Route Number,	

Division of Vital Records, P.O. Box 68760, To the Hospitel or A within 24 hours after To the Funerel Dire completely filted in by

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)
January 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
2111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)
JAN 12 2004

State

Registrar

Medical Cer

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 22, 11:30 p January 2004 Annie Rebecca Wedding /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Solomons
If Under 1 Year If Under 24 Hrs. Calvert Solomons Nursing Center 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🖫 F VA Director May 3, 213-40-9010 86 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 28a-f ahow d other than "natural", or items 23s or 28s-f show svent, the Medical Examinar must be notified at 1∭ Yes 2 □ No Director Owings MD Calvert 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20736 8310 Mt. Harmony Lane death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, important: if item 27 is marked other ther any injury or other traumatic avent, ILEA DAGE. Farmer 3 Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pharis Landris Morgal Carrie Virginia Simpson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8310 Mt. Harmony Lane, Owings, MD 20736 be of Disposition (Name of Date 20c. Location - City o Josephine Flynn/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

1 Donation 5 X Other (Specify)entombment S. Memorial Gardens 1/26/04 Dunkirk, MD 21. Signature of Euroraf Servis Licensee 22. Name and Address of Facility Raymond-Wood F.H., PO Box 430, Dunkirk, Maryland 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Week /Medical Due to (or as a consequence of) **Examiner** dvanced if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of). Box 68760. the attending physicien by Physiclan/Medical IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear detached for 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Aurising Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Natural 5 Pending investigation 1 Tes 2 No death. 2 Accident after death 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 310 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

**ORIGINAL** 

		1 For State	State of Maryland			Mental Hygi		0065
		Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> )	Certifica	ate of Death	2. Date of Death	g. No. 2001	3. Time of Death
Physici /Medi		ANNIE M.	Armstead	d	-	2/3	Joy Year	6:45A
Examir	ner		using Home	F. 1 46. Cit	y, Town, or Location of Dea	th	4c. County of Deat	h
Funeral Director	2	5. Social Security Number 6. S		Yrs. If Und Month	ler 1 Year   If Under 24 Hr		9. Birt 13 Sou	hplace (State or Foreigning)  Who (woling)
show	1	10a. State 10b. County	10c. City,	Town or Location		,		10d. Inside City Limi
r 28e-f	Director	10e. Street and Number	Ba	10f. 2	Zip Code	10	g. Citizen of What Co	
s 23a o		6617 Knotti	WOOD COUR	+ 2	11214		USA	
ine. The Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		adent of Hispanic Origin? (coeffy Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
"natur sotical	Completed	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of wo	orking	6b. Kind of Business/	Industry
giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	N /	se se	Ş	Privat	e
ntal Hygi	Be	17. Father's Name (First, Middle, Last)	o.g.		18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
Health and Mental Hyg item 27 is marked othe other traumatic event,	2	19a. Informant's Name/Relation; ip (1	ype, Print)	19b. Mailing Addre	ass (Street and Nomber or R	ural Route Number,	DSON lity or Town, State, 2	Zip Code)
lealth am 27 lum 27 lum her tra	(	Hadys L. Weld	ON (Daughter)	del 7 Kn lace of Disposition (N	ottwood Co	ur + Bala	6 MD 2	1214
0		20a. Method of Disposition  1	Removal from State	metery, crematory of	r other place)	loid P	Oc. Location - City or	Nown, Slate
Department Important: I any injury o		21. Signature of Funeral Service Licen	See Ou	Value (	and Address Pacility	RITURA	al Service	
RQ E # 9		23a. Part1. Enter the disease, or comp	Signatures that caused the death	Do not extent the m	5 year	ld Bil		1212 Approximate
hysician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		echine	o or respiratory arres		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a conseque					
i inggal	er	Sequentially list conditions if any, leading to immediate	b. Deculor Due to (or as a conseque	tts vi	w			
sicien and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Atria	2 Filos	Mater			
sicien a	cal Ex	resulting in death) Cast	Due to (or as a conseque	ence of):	les Acci	dent		
> 0		is service	d	, , , , , , ,				
ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic			23d. Date of deli Month	ivery Day Year
gned by	by Ph	Part II. Other significant conditions of	ontributing to death but not result	ting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death
been signe should be		Anaena	c,	D . A			2 No 3 Pr	
	Completed	Degenva	the Joint	Dise		24a. Was an autopsy performe	prior to death? ⊇No 1 ☐ Yes	topsy findings avail completion of cause
	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 0	0.1	ath <i>(Check only one)</i> Home 5 ☐ Residen	ce 6 □Other (Spec	cify)
r death. actor: After this certificaby the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury al Work? 1 Tyes 2 No	28d. Describe how		
within 24 hours after death.  To the Funaral Diractor: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, elc. (Specify)	ne, farm, sireet, facto	ory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Funar Funar tely fill	edical	29a. Certifier  (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my know iner: On the basis of examination	ledge, death occurre on and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
vithin 2 Fo the	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number	290	I. Date signed (Month	n, Day, Year)
> m ()		> Start	MI		D31464		2/6/04	
37								
X		30. Name and address of person who of Strangers ALS ALS HASH	completed cause of death (Item 2	23a) (Type, Print)	w St Smit	2 = 0	2	mi) a

· Aron Alston

		RegistrarAMFND TTFM	m #1 ber me State of M #23a,Part II,2 #5 PER FH G829	3/04/04 JH	Tillicate of	Dodin	1	leg. No.		03656	
Physic	ian	Decedent's Name (First, Midd	de, Last)Aaron Al	ston			Month	Day	Year	3. Time of Death	
/Medi		-ARON		ALST	1	and another of Death	Februa	7	2004	3:50 PM	
Exami	ner	4a. Fecility Name (If not institution			BALTIMOI	or Location of Death O다	1	4c. Cour	ily of Deeth		
		MARYLAND GENE		ge (In yrs. last birthday			8. Date of Birth	1	9 Birthol	ace (State or Foreign	
Funeral Director		5.241 Securio 6 Jumber	XX M 2□F	53 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 12/13/	1950	Count	EL HILL, N	
p .		Usual Residence of Decedent  10a, State  10b, Count	v	10c. City, Town or L	ocation				10	Od. Inside City Limits	
the Marylar 28a-f ahow	tor	MD	,	BALTI						1∭Yes 2 □ No	
the	rec	10e. Street and Number		1	10f. Zip Code			10g. Citizen o	of What Count	try?	
23a or	Q I	1744 FULTON A	VENUE		2121	7		U.S	.A.		
ter deat	Jera	11. Marital Status UNK	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. R	ace - America lack, White, e		
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Itema 23s or 28s-1 show other traumatic event, the Mydical Exams or must be notified at	Completed by Funeral Director	1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 XX es 2 :	No	1 ☐ Yes 2 XX		o 110411, 610.)		city: BLA		
2 hou	ted	15. Decede	nt's Education	16a. Dec	edent's Usual Occup	pation	I SAIN	16b. Kind of	Business/Ind	lustry UNK	
hin 7	ble	Elementary/Secondary (0-12)	est grade completed)  College (1-4or	5+) (GIV life.	e kind of work done DO NOT use retire	auring most of wor d)					
should be filed withir nd Mental Hygiene. marked other than imatic avent, the M	E O	12									
buld be filed Mental Hygi arked other attc event.	Be	17. Father's Name (First, Middle	, Last)			18. Mother's Nar					
Menta	10 8	LACY ALSTON				ESSIE I	PUREFOY  Rural Route Number, City or Town, State, Zip Code)				
2 short and N le me		19a. Informant's Name/Relation	iship (Type, Print)	19b. Mai	ing Address (Street	and Number or Ru	ıral Route Numbe	r, City or Tow	m, State, Zip	Code)	
1 and 2 Health (sem 27 ligher tra		ELVA WRIGHT -	SISTER	55	09 BELAIR	ROAD, BA	ALTIMORE	, MD 2	1206		
of He Item		20a. Method of Disposition	VM-	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ice)	Date	20c. Location	n - City or To	wn, State	
Pages nent of I ant: If It		1 Burial 2 Cremation 4 Donation 5 Other		9	LHILL CEM		ויניסבין (	LHAPEL H	lill, NC		
permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr 2008.		21. Sign for of Funeral Service			22. Name and Addre		MARYLAND				
81 5				01140 4	ZO CRAIN	III CTIIWA I				Z 1 1 1 0 1	
Physician		Immediate Cause (Final disease or condition		ed the death. Do not en		ng, such as cardiad	or respiratory are	rest,		Approximate Interval Between Onset and Death	
/Medical Examiner	cal Examiner	Immediate Cause (Final	a. Hypert  Due to (or a  b  Due to (or a	ensive Atheros a consequence of):  a a consequence of):  a a consequence of):		ng, such as cardiad	or respiratory are	rest,		Approximate Interval Between	
certificate be executed with a second continuation and continuation and continuation and certificate as the burial-transit	cal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d	ensive Atheros a consequence of):  a a consequence of):  s a consequence of):  e of pregnancy 2   Fetal death 3		ng, such as cardiac	or respiratory are	e 23d. [	Date of delive	Approximate Interval Between Onset and Death	
certificate be executed with a second continuation and continuation and continuation and certificate as the burial-transit	cal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Clive birth 4 Pregnant 9 Unknown	ensive Atheros a consequence of):  a a consequence of):  s a consequence of):  e of pregnancy 2	□ Ectopic pregnanc	ng, such as cardiac	c or respiratory and	23d. D	Date of deliver	Approximate Interval Between Onset and Death	
so that the death certificate be executed  Take a property of the attending physician and by the attending physician and detached for use as the burlal-transit	cal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown	ensive Atheros a consequence of):  a a consequence of):  s a consequence of):  e of pregnancy 2	□ Ectopic pregnanc	ng, such as cardiac	lar Disease	23d. D	Date of deliver Month	Approximate Interval Between Onset and Death  fy Day Year	
The law requires that the death certificate be executed as the las been signed by the attending physician and page 2 should be detached for use as the burlat-transit	cal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown	ensive Atheros a consequence of):  a a consequence of):  s a consequence of):  e of pregnancy 2	□ Ectopic pregnanc	ng, such as cardiac	23e. Did to 1 Y	23d. [	Date of delivered Month  Ontribute to the second prior to condeath.	Approximate Interval Between Onset and Death  ry Day Year e cause of death?	
The law requires that the death certificate be executed a state has been signed by the attending physician and page 2 should be detached for use as the burlat-transit	e Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Cive birth 4 Pregnant 9 Unknown tions contributing to death	ensive Atheros a consequence of):  a a consequence of):  s a consequence of):  e of pregnancy 2	□Ectopic pregnanc □ Other (specify) underlying cause gi	ong, such as cardiace  Cardiovascu  Ey  ven in Part I.  26. Place of Dei	23e. Did to 1 Y	23d. D. Months and D. Months a	Date of delivered Month  Ontribute to the second prior to condeath.	Approximate Interval Between Onset and Death  Ty Day Year  e cause of death? abily 4 280 Inknown bosy findings available inpletion of cause of	
ystician: The law requires that the death certificate be executed as is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of the condition of	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown tions contributing to death	ensive Atheros a consequence of):  a a consequence of):  s a consequence of):  e of pregnancy 2	□ Ectopic pregnanc □ Other (specify) underlying cause gi	cy ven in Part I. 26. Place of Dec	23e. Did to 1 Yes	23d. I	Date of delivered on the second of the secon	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death?  Paper Secure of death?	
Physician: The law requires that the death certificate be executed to be the certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burlal-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. Pregnant 4 Pregnant 9 Unknown tions contributing to death Lism Hospital: 1 Minpal 28a. Date of in	ensive Athero s a consequence of):  a a consequence of):  a a consequence of):  a consequence of):  a consequence of):  a consequence of):  but not resulting in the  a consequence of):  but not resulting in the	□Ectopic pregnanc □ Other (specify) underlying cause gr	ey  ven in Part I.  26. Place of December: 4 \subsection Nursing H	23e. Did to 1 Yes  ath (Check only or	23d. [ Months of the control of the	Date of delivered Month  Ontribute to the state of the st	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death?  Paper Secure of death?	
Physician: The law requires that the death certificate be executed to be the certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burlal-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Due to (or a d. Pregnant 9 Unknown tions contributing to death ism  Hospital: 1 X Inpa 28a. Date of in (Month, D 28e. Place of to 28e. Place of to	ensive Athero s a consequence of):  a a consequence of):  a a consequence of):  a consequence of):  a consequence of):  a consequence of):  but not resulting in the  a consequence of):  but not resulting in the	DEctopic pregnanc Other (specify)  underlying cause given  ant 3 DOA of 28c. Inju Wo M	ven in Part I.  26. Place of Deither: 4 \( \text{Nursing } \)	23e. Did to 1 Yes 24a. Was autop perfor 1 Check only on	23d. I. Months and I. Months a	Date of deliver Month  antinbute to the autoprior to condeath Yes  Other (Specify curred	Approximate Interval Between Onset and Death  Ty Day Year  e cause of death? ably 4 Authoroun one findings available inpletion of cause of 2 No	
Physician: The law requires that the death certificate be executed to be the certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burlal-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Due to (or a d. Pregnant 9 Unknown tions contributing to death ism  Hospital: 1 X Inpa 28a. Date of in (Month, D 28e. Place of to 28e. Place of to	ensive Atheros a consequence of):  a a consequence of):  a a consequence of):  a of pregnancy 2 Fetal death 3 at time of death 5  but not resulting in the  tient 2 ER/Outpatic jury ay Year)  28b. Time ay Year)  at c. (Specify)  at of my knowledge, dea of examination and/or	DEctopic pregnance Other (specify) underlying cause grounderlying	ven in Part I.  26. Place of Deather: 4 \( \triangle \) Nursing Heart in R?  1) Yes 2 \( \triangle \) No	23e. Did to 1 Yes  ath (Check only or  28f. Location (S City or Tow	23d. I. Months and the state of	Date of deliver Month  Sometime to the state of the state of deliver to condeath?  Other (Specify the state of the state o	Approximate Interval Between Onset and Death Onset and Death Onset and Death Pay Year Be cause of death?  abily 4 (20 Inknown pay findings available inpletion of cause of 2 No	
Physician: The law requires that the death certificate be executed to be the certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burlal-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a ling tire birth 4 Pregnant 9 Unknown tions contributing to death Lism  28a. Date of In (Month, D tiring Physician: To the besi al Examiner: On the basis and manner services.	ensive Atheros a consequence of):  a a consequence of):  a a consequence of):  a of pregnancy 2 Fetal death 3 at time of death 5  but not resulting in the  tient 2 ER/Outpatic jury ay Year)  28b. Time ay Year)  at c. (Specify)  at of my knowledge, dea of examination and/or	DEctopic pregnanc Other (specify) underlying cause grounderlying grounderlying cause grounderlying gro	ven in Part I.  26. Place of Deither: 4 Nursing Hirk?  17 Yes 2 No  18 No date and place opinion, death occurs on number	23e. Did to 1 Yes  ath (Check only or  28d. Describe h  28f. Location (S City or Tow	23d. I. M. Debacco use coores 2 No ne. No ne	Date of deliver Month  3 Proba  b. Were autoprior to condeath?  Cher (Specify curred)  manner as stee, and due to med (Month, 1)	Approximate Interval Between Onset and Death Onset and Death Onset and Death Pay Year  e cause of death?  ably 4 [24] Inknown pletion of cause of 2 [20] No  Provided Number, atted, the cause(s)  Day, Year)	
The law requires that the death certificate be executed as the las been signed by the attending physician and page 2 should be detached for use as the burlat-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that imitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Hypert Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a ling tire birth 4 Pregnant 9 Unknown tions contributing to death Lism  28a. Date of In (Month, D tiring Physician: To the besi al Examiner: On the basis and manner services.	ensive Atheros a consequence of):  a a consequence of):  a a consequence of):  a of pregnancy 2 Fetal death 3 at time of death 5  but not resulting in the  tient 2 ER/Outpatic jury ay Year)  28b. Time ay Year)  at c. (Specify)  at of my knowledge, dea of examination and/or	DEctopic pregnanc Other (specify) underlying cause grounderlying grounderlying cause grounderlying gro	ven in Part I.  26. Place of Decher: 4 \(  Nursing First Part Part Part Part Part Part Part Par	23e. Did to 1 Yes  ath (Check only or  28d. Describe h  28f. Location (S City or Tow	23d. Description of the control of t	Date of deliver Month  3 Proba  b. Were autoprior to condeath?  Cher (Specify curred)  manner as stee, and due to med (Month, 1)	Approximate Interval Between Onset and Death Onset and Death Onset and Death Pay Year  e cause of death?  ably 4 [24] Inknown pletion of cause of 2 [20] No  Provided Number, atted, the cause(s)  Day, Year)	

DHMH 17 Rev 1/2001

State Registrar

DOS Amend ItemPart XII, Per ME C828. 3/3/0/462. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 00671State of Maryland / Department of Health and Mental Hygiene 2004 James R. Alban 03657 1- For State Unpended Item#23a, Part II, 27, 28a-f, Per Will Case 2/13/10/104 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2004 438 24 James Robert Alban January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore ESSEX Apt. F 1404 Shade Tree Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) March 30,1953 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∑**M 2□ F 449-02-0173 50 Maryland Director Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral', or itema 23a or 28a-f ahow Examinar must be notified at 1 ☐ Yes 2 📉 No Baltimore Baltimore Maryland Directo the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21221 United States 1170 Boxwood Lane Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white þ 3 Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12maintenance representative computer other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic avant 90cg. 17. Father's Name (First, Middle, Last) Be Margaret Roth Edgar H. Alban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert L. Alban, Sr./uncle Freeland, MD 2464 E. Ruhl Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount Crematory Feb. 9, 2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faculty edefeld Funeral Home Inc Mitchell-Wiedefeld Funeral Home Inc Baltimore, MD 21212 21. Signature of Funeral Service Licensee IIV John O. Mitchel Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she or heart failure. List only one cause on each line. Immediate Cause (Final Narcotic Intoxication **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical for use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ pe Cocaine Use, Hypertensive Atheroselerotic Cardiovascular Disease 3 Probably 4 Unknown 1 ☐ Yes 2 D(No Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: 1 Yes 2 🗆 No 2 No 1 Yes certificate Attending Physician: After this certification funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical avaminer' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\square\!\!\!\!$ Other (Specify) at scene Yes 2 No Medical Certification: To 28a. Date of Injury **for Ma**nth, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending found'y unknown 1 ☐ Yes 2 No death. investigation 1/24/04 4:20 2 Accident the a within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found in apartment 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ö 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) January 24 2004 29c. License number 29b. Signature and title of certifier **OCME** Jours 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Gree sha Ci 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da **Physician** /Medical 4b, City, Town, or Location of Death Name (If not institution, give 4c. County of Deeth Examiner Security Number 6 Sax (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min 1 ☐ M 2[**X**F Director sual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, I'm Marical Examinant and I have mad be notified as any injury or other traumatic event, I'm Marical Examinant and I have mad be notified as Yes 2 □ No Director Ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ Xlo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done of life. DO NOT use retired during most of working ondary (0-12) College (1-4or 5+) To Be BITISON Rural Route Number, City or Town, State, Zip Code) ne/Relationship (Type, Print) 19b. Mailing Address (Street and Nurfit Place of Disposition to MD TON d of Disposition Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has autopsy performe res 21 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 🗌 Yes 2 ER/Outpatient 1 🗌 Inpatient DOA 27. Manner of Dea completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Dey, Year) who completed cause of death (Item 23a) (Type, Print) MO, PA 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

10

2004

**ORIGINAL** 

32 Registrar's Signature

			State of Maryl	•			ental Hy	giene 200L	03660
			Registrar	Cei	rtificate of l	Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)				Month TO ALTV	Day 200	1 10:139M
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	receivery	4c. County of Deat	
	Examili	er	ST. Agnes Heath Care		Baltin	more		nIB	
4	Funeral		5. Social Security Number 6. Sex 7. Age (In )	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, rear) Co	thplace (State or Foreign
	Director	0	11/16 65/9	Yrs.			SEPT. Si	5,1968 MA	
	land w		Usual Residence of Decedent           10a. State         10b. County         10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary Ff sh	tor	enercloso N/m	BAI	HHOR				1 Des 2 □ No
·	ith the Marylar or 28e-f show a notified at	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	untry?
	23a		31 N. Culuan StrEET		0.	1229		USA	
	172 hours after death with the Maryla "natural", or lieme 23s or 28e-f show idleal Exercities from be redified.	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	- 14. Race - Ame Black, Whit	
21215-0036	irs att	by F	1 ☐ Never Married ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ➡ No	Specify:		Specify:	0 %
9-0-	72 hours natural;	ted	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	00	16b. Kind of Business	
218	thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired		, g	AT ONCG	Jan torial
	led wi lygien har th	Con	1/H grade	+1001	- IECHN	ICIAN	15: 14:	SETULCE,	
and	ntal H ed of	Be	17. Father's Mame (First, Middle, Last)			18. Mother's Name		Maiden Sumame)	
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hygjene. • marked other than "natural", or iteme 23e or 28e-f show umatic event, the Medical Exercities treat by crofified at	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Street			ar, City or Town, State, 2	Zip Code)
	and 2 sealth ar n 27 io	1	Breason Blue lwife	3/1.	Culuar	Street	Baltu	~	tro 2/229
Je,	of Heal			b. Place of Dispo	sition (Name of matory or other place	ce) D	ate	20c. Location - City or	
ino in	Pages nent of I ant: if it		1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 1 → 4 ☐ Donation 5 ☐ Other (Specify)	f. Lion		0/6	104	solfinor 1	mary/oxx
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any rightry or other freumatic event, ITE MODE.		21. Signature of Funeral Service Islansee	22	2. Name and Address	ss of Facility C //	ATHA	-Kmis	Fineral Home
	65502		Jerry Hurrs			Med 2			A
			23a. Part V Enter the disease, or complications that caused the canada have. List only one cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a card	Lange	ular	25025	nkown
Fja	Examiner		Due to (or as a con	sequence or):					
	⇒ <u>,</u> †	ner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	sequence of):					
6/	and I-transit	Examiner	Cause (Disease or injury that initiated events c.						
20,0	cate be executed physicien and the burial-transit		resulting in death) Last Due to (or as a con	sequence of):				I	
8760,		dicai	d						
Box 6	eath certitic attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. Date of de	iverv
. Be	death e atter	iciai	in the past 12 months?  1 Very 2 No. 4 Pregnant at time		]Ectopic pregnancy ] Other <i>(specify)</i>	'		Month	Day Year
0.0	that the de ed by the detached	hys	9 Unknown						
5	The law requires that the death certition is the has been signed by the attending to age 2 should be detached for use as	by F	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.		obacco use contribute to	
O.O.	v requires been sign should be	Completed			·				obably 4 Unknown
Je C	ie law has t je 2 s	mpi					24a. Was autop perfo		itopsy findings available completion of cause of
Z E		e Co	25. Was case referred to medical			00 Bloom of Brook	1 ☐ Yes	2. No 1 ☐ Yes	2 🗆 No
30 1	Physician: this certific ral director,	To Be	examiner? Hospital:	ER/Outpatier	nt 3 DOA Oth	er: 4 \ Nursing Hor		ne) dence 6 □Other (Spe	city)
٥		T:U	27. Manner of Death 28a. Date of Injury	28b. Time of		y at k?		now injury occurred	
ion		atic	2 Accident investigation	,,,		Yes 2 □ No			
D X	⊒ ijet o	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury : 4 ☐ Homicide building, etc. (Science)	At home, farm, str pecify)	reet, factory, office	2	28f. Location (5 City or Tox	Street and Number or Ri vn, State)	ural Route Number,
0	ospitel or A hours after uneral Directly tilled in by	a Ce	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	h occurred at the tin	ne, date and place, a	and due to the	cause(s) and manner as	stated.
3	To the Hospitel or within 24 hours atter To the Funeral Dir completely tilled in	edic	(Check only one) To Medical Examiner: On the basis of examiner and manner stated.	nination and/or in	vestigation, in my o	pinion, death occurre	ed at the time,	date and place, and due	to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier	15: 1	29c. Licens	e number		29d. Date signed (Mont	
•	2		Xanna Jamola	ND	D3:	3001	+	c Bolt	6,2009
//			Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	+ Hast	1 000	- Ralt	mace
	Sta	ite	S1. Date filed (Month, Day, Year)  32. Begistrar's S	ignature	11900	2 Chack	Ch COI	0 0000	11.0.0
	Registi		FEB 1 0 2004	Ji A	make.				

					ndelible Ink. Ensure A	•		
		•	1 - State Registrar		artment of Health and Nertificate of Death	Mental Hygie Reg	C 0 0 4	03661
	Physici /Medic		Decedent's Name (First, Middle, Last)     ADA		BECKER	2. Date of Death Month FEBRUARY	5, 2004	3. Time of Death 5:30 P M
	Examir	er	4a. Facility Name (If not institution, give street  NORTH OAKS HEALTH  5. Social Security Number 6. Sex		4b. City, Town, or Location of Death PIKESVII If Under 1 Year If Under 24 Hrs.			LTIMORE
	Funeral Director		217-92-9822		Months Days Hours Min.	8. Date of Birth (Month, Day, Y SEPT 25,	1914	hplece (State or Foreign untry) MD
	Ba-f show	Director	10a. State 10b. County  MD BALTIMOR	10c. City, Town or L	ocation KESVILLE			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with th		10e. Street and Number 725 MT. WILSON LAN		10f. Zip Code 21208		. Citizen of What Co	U.S.A.
9036	n 72 hours after death with the Maryland "natural", or Itams 23s or 28s-1 show salical Expandent must be notified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces?  ☐ Yes 2 M No Yes, Give ear or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within ene. then *	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) Company (1-12) Company (1-	pleted) (Give life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) SEWIFE	ring	b. Kind of Business/	industry
Maryland 2	be file ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) HARRY	GORE	18. Mother's Nam	e (First, Middle, Ma.		ERENBERG
	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, P.  LARRY BECKER / SC  20a. Method of Disposition		ing Address (Street and Number or Rur . WOODVALLEY DRIVE	- BALTIMO	ORE, MD 2	1208
Baltimore,	permit. Peges of the permit of the permit of the permit of the sany injury or of the permit of the p		1 A Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. Sortium of Funeral Service Lights	al from State BETH TFI	INDUSTRIES OF STREET STORY STREET STORY STREET STORY STORY STEET STORY STREET STORY STREET STORY STREET STORY STREET STORY STORY STREET	/2004 _ LEVINSOI ROAD - PII	KESVILLE.	, MD , INC.
	Physician /Medical		23a. Part 1. Enter the disease, or combination shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	1 11	rt failure			Approximate Interval Between Onset and Death
68760,	physician and purial-transit	Ical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	Cardioverscular	01800	7e	10 years
P.O. Box 68	death certif e attending od for use as	Physiclan/Medical	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deli	very Day Year
	equires thaten signed and signed be de	by	Part II. Other significant conditions contribut	ing to death but not resulting in the (	underlying cause given in Part I.			the cause of death?
of Vital Records,	The ate h page	Completed				24a. Was an autopsy performed 1  Yes 2	d? prior to death?	topsy findings available completion of cause of
Z.	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospit.	al: 1  Inpatient 2 ER/Outpatie	Out.	h (Check only one)	e 6 □Other (Spec	7.
	ath. r: After	$\vdash$		a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how		eny)
Division	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	4 Homicide	e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, S		
V	n 24 hou n 24 hou ne Fune	edical	2 Medical Exeminer: C	: To the best of my knowledge, dea on the basis of examination and/or in nd manner stated.	th occurred at the time, date and place, exestigation, in my opinion, death occurr	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Comp	W	29b. Signature and title of certifier	MO	29c. License number 0 3 8 6 7 5		Date signed (Month	5 2004

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOEL MESHULAM 30 | ST PAUL PL S

31. Date filed (Month, Day, Warf.\*\*)

32. Registrar's Sonature

SHULAM 301 ST PAUL PL SVITE GOT BALTIMONE MO 21202

YEAR 32. Registrar's Signature

FEB 10 2004 Secure Security 
ORIGINAL

		For State Registrar	te of Marylan	d / Depa		ealth and	Mental Hyg	iene g. No. 20	03662
Physicia /Medic Examin	al .	Decedent's Name (First, Middle, Last)     Ir     Aa. Facility Name (If not institution, give street a 53 Chesapeake Mobile)		Booker	4b. City, Town, or		2. Date of Dear Month Februar	Day y 4 2	Year 004 8:40 A. M of Death Arundel
Funeral Director		5. Social Security Number 219 32 2235 6. Sex 12 M 2 Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hi Hours Mi		<sup>Year)</sup> 1938	9. Birthplace (State or Foreign Country) Maryland
Tey, Middly jidlicd X 12.15.15.15.15.15.15.15.15.15.15.15.15.15.	Completed by Funeral Director	10a. State  10b. County  Maryland  Anne Arund  10e. Street and Number  53 Chesapeake Mobil  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  15. Decedent's Education  (Specify only highest grade comp.	el H  e Court  s Decedent Ever in U ned Forces?  Yes 2 \( \sum \) No es, Give ar or Dates:	16a. Dece (Give life.	10f. Zip Code 210° Was Decedent of H f Yes, specify Cuba 1 □ Yes 2₺ No dent's Usual Occup kind of work done o	spanic Origin? n, Mexican, Pue Specify: ation furing most of w	(Specify Yes or No- arto Rican, etc.)	Specify 16b. Kind of Bu	e - American Indian, ck, White, etc.  White usiness/Industry
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, than manual control of the ma	To Be Com	10 17 Father's Name (First, Middle, Last) Marcus T. E	ooker		ck Drive	18. Mother's N	ame (First, Middle, a	Maiden Sumam Grimm	
permit. Pages 1 and 2 sh Department of Health and Important: If item 27 1e any injury or other traum once.		19a. Informant's Name/Relationship (Type, Pri Loretta Booker /  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova  1 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	wife 20b. F	53 Ch Place of Dispo cometery, crea en Have	ng Address (Street :  lesapeake sition (Name of natory or other place en Mem. P  Name and Address Oll Ritch	Mobile ark 2/7	Date 7/2004 (Gonce Fund	nover, 20c. Location - Glen Bur eral Se	Maryland 21076 City or Town, State rnie, Maryland rvice, P.A. Maryland 21225
Physician are percented // Medical Examiner and portion and provided in provided in the private of the private	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consecute to (or as a consec	quence of):	er the mode of dyin	g, such as card	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
the death certificate the death certificate by the attending physisched for use as the	Physician/Medic	in the past 12 months?	res, outcome of pregn ]Live birth 2   Feta ]Pregnant at time of c ]Unknown	aldeath 3	⊒Ectopic pregnancy ∃ Other <i>(specify)</i>				te of delivery onth Day Year
The law requires that the de-	Completed by Pi	Part fl. Dther significant conditions contributi	ng to death but not res	sulting in the u	inderlying cause giv	en in Part I.	24a. Was a autop perfor	es 2 No	tribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director, After this certificate completely filled in by the funeral director, page	Certification: To Be	2 Accident investigation	il: 1 Inpatient 2	28b. Time of Injury	f 28c. injur Wor M 1	er: 4 🗆 Nursing	28d. Describe h	ence 6 Oth	
To the Hospital within 24 hours a To the Funeral I comulately filled	Medical Ce	29a. Certifier (Check only one)  29b. Signature and title of certifier				pinion, death o	courred at the time, o	late and place,	
Sta Registr	rar	30. a Land address of person who mplet and address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person who mplet are also as a second address of person are also as a second address of person and address of person are also as a second address of person are a second ad	ed cause of death (Ite	ature	Print)	110	( ) ( )	n Din	14.364

Dhyoi	ion	1. Decedent's Name (First, Middle, Las	Ob PER FH G828 2/			Death	2. Date of Dea		3. Time of Death
Physic /Med Exami	ical	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of De	02	Day Year O	4 10:30A
Funera Director		5. Social Security Number 6. Se	ex 7. Age (In yrs	S PI+Q s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	s. 8. Date of Birt	9. E 9. 1940 N	Birthplace (State or Foreig County) ARYLAND
e Maryland ta-f show	ctor	10a. State 10b. County	10c. C	BALTI	more E				10d. Inside City Limit:
ith with th 23a or 26 ust the no	Funeral Director	10e. Street and Number BRAOH	URST ROMO	•	10f. Zip Code	21212		10g. Citizen of What	
72 hours after death with the Maryland natural, or Itams 23a or 28a-f show dical Examire must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Fer in the Armed Forces 1 The Second 1 T		as Decedent of P Yes, specify Cub	dispanic Origin? an, Mexican, Pue Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc.
within ene. than '	Completed	15. Decedent's Ed (Specify only highest gran Elementary/Secondary (0-12)		(Give ki	ent's Usual Occup ind of work done O NOT use retire	during most of w		16b. Kind of Busines	ss/industry
be filed htal Hyg ed othe evant,	To Be C	17. Father's Name (First, Middle, Last) WILSON	URTIS				ame (First, Middle,		1
s 1 and 2 should of Health and Meritam 27 is marke other traumatic		19a. Informant's Name/Relationship (7 KAREN T. CUR	TIS WIFE	807	BRADA	HURST		r, City or Town, State ACTO, M	
permit. Pages 1 Department of H Important: If ita any injury or otl		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen:	K	Place of Disposition Company C	tion (Name of MR) MR Per pla	ss of Facility V	PUBLIN C	20c. Location - City of MOTO MOTO CORRECTION	ENERAL HOM
		23a Part 1 Enter the disease or comm	DUNC	79	US Y <i>0</i> ≥	K KITTU	BAUIM	ME MARY	LAND 21212
Physician		23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the dea	ath. Do not enter	the mode of dyir	ng, such as cardia	ac or respiratory arr	est,	Approximate interval Between Onset and Death
Medical Examiner  Associate and Associated and Asso	Ilcal Examiner	Immediate Cause (Final	a. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	the mode of dyir	ng, such as cardia		est,	Approximate interval Between
Medical Examiner  Associate and Associated and Asso	cal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End.  Due to (or as a consect  Due to (or as a out con  c.	quence of):  quence of):  quence of):	ctopic pregnancy	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
Medical Examiner  Associate and Associated and Asso	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregnant at time of a go Unknown	quence of):  quence of):  quence of):  annoy al death 5 0	ctopic pregnancy	eng, such as cardi	ac or respiratory arr	23d. Date of d Month	Approximate Interval Between Onset and Death Onset and Death
sw requires that the death certificate be executed by the attending physician and consigned by the attending physician and consider should be detached for use as the burial-transit	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions conditions.	a. Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d. 23c. If yes, outcome of pregnant at time of a go Unknown	quence of):  quence of):  quence of):  annoy al death 5 0	ctopic pregnancy	en in Part I.	23e. Did tol 1 Yes 24a. Was a autops perfort	23d. Date of d Month  Dacco use contribute es 2 \( \text{No} \) 3 \( \text{F} \)  The standard of the standard	Approximate Interval Between Onset and Death Onset and Death Death Onset and Death?  Probably 4 Junknow autopsy findings available completion of cause of
sw requires that the death certificate be executed by the attending physician and consigned by the attending physician and consider should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consect b. Due to (or as a consect b. Due to (or as a consect d. Due to (or as a co	quence of):	ctopic pregnancy Other (specify) erlying cause giv	en in Part I.  26. Place of Deer: 4 \( \text{\substack} \) Nursing	23e. Did tol 1 Yes 24a. Was a autops perforn	23d. Date of d Month  Dacco use contribute es 2  No 3  Fine of death? 1  Ye e)  since 6  Other (Sp	Approximate Interval Between Onset and Death Onset and Death Death Onset and Death Pay Probably 4 Qunknow autopsy findings available completion of cause of the c
sw requires that the death certificate be executed by the attending physician and consigned by the attending physician and consider should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown  Part II. Other significant conditions conditions conditions conditions conditions conditions are referred to medical examiner?  1 yes 2 No  25. Was case referred to medical examiner? 1 yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	a. Due to (or as a consect.)  Due to (or as a consect.)  C. Due to (or as a consect.)  Due to (or as a	quence of):  quenc	ctopic pregnancy Other (specify) erlying cause giv  3 □ DOA Oth 28c. Injun Word M 1 □	en in Part I.  26. Place of Deer: 4 \sum Nursing is	23e. Did tol 1	23d. Date of d Month  Dacco use contribute es 2 No 3 F  1 24b. Were a prior to death? 2 No 1 Ye e)  In ye e) In ye e)  In ye e e  In ye	Approximate Interval Between Onset and Death Onset and Death  elivery Day Year  to the cause of death? Probably 4 Unknown autopsy findings available completion of cause of the cause of th
sw requires that the death certificate be executed by the attending physician and consigned by the attending physician and consider should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions conditions are conditions of the	a. Due to (or as a consect.)  Pregnant at time of consect.  Due to (or as a consect.)  Due to (or as a consect.)  Pregnant at time of consect.  Due to (or as a consect.)  Due to (or a	quence of):  quenc	ctopic pregnancy Other (specify) erlying cause giv  3 DOA Oth 28c. Injun Worl M 1 the control of	en in Part I.  26. Place of Deer: 4 \( \) Nursing to at k?	23e. Did tol 1 Yes 24a. Was a autops perfort 1 Yes 2 ath (Check only on the check on the c	23d. Date of d Month  Dacco use contribute es 2 \( \text{No} \) 3 \( \text{F} \) end? 24b. Were a prior to death; 1 \( \text{Ye} \) ence 6 \( \text{Other (Sp} \) ence 6 \( \text{Other (Sp} \) ence w injury occurred	Approximate Interval Between Onset and Death Death Onset and Death
sw requires that the death certificate be executed by the attending physician and consigned by the attending physician and consider should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any loading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conserb. Due to (or as a co	quence of):  quenc	ctopic pregnancy Other (specify)  erlying cause giv  3 □ DOA Oth  28c. Injun World  t, factory, office	en in Part I.  26. Place of Deer: 4 \( \triangle \) Nursing to the end place of the end place.	23e. Did tol  23e. Did tol  1	23d. Date of d Month  Dacco use contribute es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 3 \( \text{Position} \) es 4 \( \text{No} \) 4 \( \text{No} \) es 6 \( \text{Other } (Sp) es 4 \( \text{No} \) 6 \( \text{No} \) 6 \( \text{No} \) es 4 \( \text{No} \) es 4 \( \text{No} \) es 4 \( \text{No} \) es 5 \( \text{No} \) es 6 \( \text{Other } (Sp) es 6 \( \text{No} \) es 6 \	Approximate Interval Between Onset and Death Onset and Death Onset and Death Pay Year Day Holland Pay San Day Onsective D
requires that the death certificate be executed to signed by the attending physician and include be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consect.)  C. Due to (or as a consect.)  Due to (or as a consect.)  1   Live birth   2   Fed.    4   Pregnant at time of one of the consect.    1   Impatient   2    28a. Date of Injury   At he building, etc. (Speci.)  Particular: To the best of my known inter: On the basis of examinations.	quence of):  quenc	ctopic pregnancy Other (specify)  erlying cause giv  3 DOA Oth  28c. Injun Worl  t, factory, office ccurred at the tim stigation, in my of	en in Part I.  26. Place of De er: 4 \( \triangle \triangle \) No  27. All Nursing I var	23e. Did tol  23e. Did tol  1	23d. Date of d Month  Dacco use contribute es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 2 \( \text{No} \) 3 \( \text{F} \) es 3 \( \text{Position} \) es 4 \( \text{No} \) 4 \( \text{No} \) es 6 \( \text{Other } (Sp) es 4 \( \text{No} \) 6 \( \text{No} \) 6 \( \text{No} \) es 4 \( \text{No} \) es 4 \( \text{No} \) es 4 \( \text{No} \) es 5 \( \text{No} \) es 6 \( \text{Other } (Sp) es 6 \( \text{No} \) es 6 \	Approximate Interval Between Onset and Death Onset and Death Onset and Death Pay Year to the cause of death? Probably 4 AlUnknown autopsy findings available completion of cause of the cause of the same of the cause of the caus

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Physician MARION COLLINS ELIZABETH Fe brug 2004 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth ounty of Deeth Examiner lestown Nort TIMOR TONSVILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
1/19/1907 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2XX Days 97 Winstead, CT 009-32-4966 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryler Dependment of Heelth end Mentel Hygiene. Important: if itam 27 is marked other than "natural", or itams 23s or 28s-f show any Injury or other traumstic event, the Medical Examinar must be notified at 1 ☐ Yes XX No Director MD BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 709 MAIDEN CHOICE LANE, 1S 21228 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXIV off Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) VT Free Public 12 librarian 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES FOSKETT GERTRUDE GATTER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTOPHER R. COLLINS - SON 788 LOCUST CIRCLE, ARNOLD, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3XX emoval from State GREEN MOUNTAIN CEMETERY UNK MONTPELLIER, VT 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 CREGORY FINK MO1148 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown ģ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 [Naturel 5 Pending investigation s efter dec. Injury 1 Tes 2 No 2 Accident in 24 hour. the Funeral Direc. 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai o within 24 hours of To the Funeral DI completely filled in 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

29b. Signeture and title of

31. Dete filed (Month, Dey, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Maiden

Tepera

32. Registrar's Signature

Stone

**DHMH 16 Rev 6/95** 

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, MD 21228

LINWOOD ALBERT CURTIS

State of Maryland / Department of Health and Mental Hygiene

	0	73	p	jes	Į.
1		15	6	Jan.	űe-
8	1	10	U	1	3.,

			Registrar			Ce	ertificate of	Death		Reg. No.	007	00000
	Dharais		1. Decedent's Name (First, Middle, I	ast)					2. Date of E	Death Day	Year	3. Time of Death
	Physic /Medi		Linwood	Albe	rt	Curt	is		FEB.	3, 200		0719 A <sup>M</sup>
	Examir		4a. Fecility Name (If not institution, g				4b. City, Town,	or Location of De	ath	4c. Cour	nty of Death	
			1808 NORTH DUKE					ORE CIT			/A	
229	Funeral Director		217-76-9898	Sex M∑M 2□F	7. Age (In)	vrs. last birthday Yrs.	If Under 1 Year   Months   Days			lirth Da <i>y, Year)</i> 58	Cou	place (State or Foreign ntry) Cimore, Md
	land .		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation				1	10d. Inside City Limits
	Maryl -f sho	ō	Md. N/A			Baltir	nore					1 XYes 2 ☐ No
	r 28a	rec	10e. Street and Number			- 02 0 21	10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	h with	0	1808 N. Dukel	land St			2121	L6		USA		
	sms s	Funeral Director	11. Marital Status	12. Was Dec	edent Ever i	n U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or N		ace - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exams at must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes If Yes, Gir Year or □	2∭∑No ve		1 □ Yes 🛣 No		orio riioari, oto.,	Spec		ack
ر ک	72 h 'natu	etec	15. Decedent's (Specify only highest g	Education trade completed)		16a. Dece (Give	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of w	rorking	16b. Kind of	Business/In	dustry
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use retire			Cong	t 2011 0 ±	ian C-
9	filed Hygie other		17. Father's Name (First, Middle, La.	st)	-	COILS	s c i u c c i c	1	ame (First, Middl			ion Co.
Maryland	lid be lental rkad c	To Be	Edward N.	Cu	rtis	Sr.		Ine		ctis	,	
ary	2 should and Men Is marka aumatic	-	19a. Informant's Name/Relationship	(Type, Print)			ing Address (Street				n, State, Zip	Code)
	1 and 2 Health a em 27 la		Inez Curtis	Mothe	r	180	08 N. Du	ıkeland	St,Bal	ltimore	e.Md.	21216
ore	of He of He fiten		20a. Method of Disposition  1 → Burial 2 □ Cremation 3	□Romoval from		b. Place of Disp	osition (Name of matory or other pla		Date	20c. Location		
Ĕ	Pag ment ent: I		`4 □Donation 5 □Other (Spec		I M		on Cem.		10-04	Lanso	drown	e,Md.
Baltimore,	permit. Pages 1 an Department of Heali Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Lic LIOYO M. Es	ensee step		Ě	step Br 300 Eut	others	Funera	l Ser,	P.A.	21217
τ			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that of	aused the d	eath. Do not en	ter the mode of dyi	ng, such as cardia	ac or respiratory	arrest,	III.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LIV	ER (	IRRH	2120				- 1/	Onset and Death
	/Medical Examiner		resulting in death)			sequence of):						
	LAGITITIES	<u>.</u>	Sequentially list conditions,	b		sequence of):						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due 10 (	(or as a cons	sequence or):						
1	al-tra	xar	that initiated events resulting in death) Last	C. Due to	(or as a cons	sequence of):						
68760	e be			d.								
9	w requires that the death certilicate be executed been signed by the attending physician and should be detached for use as the burial-transit	n/Medical	I S S S S S S S S S S S S S S S S S S S									
30X	ith ce tendii or use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out 1□Live b	come of pre		□Ectopic pregnanc	v		1	ate of delive	
O. B	ie dea the at	Physicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ant at time of		Other (specify)			~	lonth	Day Year
Δ,	The law requires that the death ate has been signed by the atte bage 2 should be detached for a	Phy	Part II. Other significant conditions	contributing to de	eath but not	resulting in the u	anderhing cause an	on in Bad I	220 Did	tobacca use co	atabuta ta th	ne cause of death?
Records,	signe d be	d by	Tarri, Gillo orginioani acidi	contributing to de	Jan Dot Hot	resulting in the c	indenying cause giv	ren in Paiti.				ably 4 Dunknown
S	w requ	Completed										
	The lav	ошо							24a. Wa: auto perf		prior to con death?	psy findings available mpletion of cause of
Viital		e Cc	25. Was case referred to medical					Of Diagonal Da	1 ☐ Yes eath Check only		1 ☐ Yes	2 🕱 No
	ysician: is certific director.	o B	examiner? 1'∑ Yes 2 ☐ No	Hospital: 1 🗆 I	npatient 2	ER/Outpatie	nt 317 DOA Oth				her (Specific	AT SCENE
Division of	ding Phys h. After this funeral di	Ilon: T	27. Manner of Death 1 ☑ Natural 5 □ Pending	28a. Date of		28b. Time o	f 28c. Injur Wor	y at rk?		how injury occu		AI SCANE
<u> S</u>	I or Attendi after death. Director: A d in by the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	he	of Injury - A	thome farm st		Yes 2 ☐ No	28f Location	(Street and Num	her or Pura	l Route Number,
2	itel or A irs after ral Direc led in by	Certification:	4 Homicide determine	buildii	ng, etc. (Spe	ecify)	reet, factory, office		City or To	wn, State)	oor or mara	rroute rumber,
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 Certifying F  2 Medical Exe	eminer: On the ba	best of my lasis of exam ner stated.	knowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occ	e, and due to the curred at the time.	cause(s) and n , date and place	nanner as sta , and due to	ated. the cause(s)
	withi To the	Σ	29b. Signature and title of certifier	1			29c. Licens			29d. Date sign	ed (Month, L	Day, Year)
•			· auetl				0.0	C.M.E		FEB.	3, 2	004
	5		30. Name and address of person who				·					
			7 4	10, HD			n Street	, Baltim	ore, Mar	yland 2	1201	
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Sig							
DHI	MH 17 Rev 1/20		FFB 1 0	2004	Daged	mar p	hon	the second				
							*					

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment of F tificate of	leaith a <i>Death</i>	and M		ene (	2004	03	666
	Physici	an	Decedent's Name (First, Middle							2. Date of Death Month	Day	Year	3. Time of	
	/Medic Examir		Lee  4a. Facility Name (If not institution,	E. Co	<u>e</u>		4b. City, Town, o	r Location o	of Death	2	4c. C	04 ounty of Death	5:30	PM
			Future Care	Cherry Woo	d		Reiste					altimon	re Co	ı
	Funeral Director		5. Social Security Number 247–54–5028	6. Sex 7. Age 12		last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 12–16–	Year)	9. Birthpl Coun S. (	ace (State of try) Carol	r Foreign
	ס		Usual Residence of Decedent	00						12-10-	50	р. С	Jaro1	па
	show	'n	10a. State 10b. County		,	, Town or Lo						10	0d. Inside Ci	ity Limits 2  No
	28a-f	Director	Md. Balti	more	Woo	odlawı	1 (B)	altin	nore	_	a. Citize	in of What Coun		
	h with		6641 Dalton	Dr.			21207				JSA		, .	
	teme teme	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?			Vas Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14	. Race - America Black, White, e		
36	should be tiled within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or iteme 23a or 28a-f ahow marked other than "natural", or iteme 23a or 28a-f ahow marked other than "natural".	by	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo		☐ Yes X☐ No	Specify:			S	pecify: Bla	ack	
9500-91212	72 hou	Completed	15. Decedent' (Specify only highest	s Education grade completed)		16a. Deced	ent's Usual Occup	ation du <i>ring</i> most	t of worki	ina 1	6b. Kind	of Business/Ind	lustry	
	within ane. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done of the NOT use retired to the Glas				Cla	ass Co.		
	Hygir other	Be Co	17. Father's Name (First, Middle, L	ast)		Car.	LUS GIA			(First, Middle, M				
Z	should be and Menta marked umatic sy	To B	Ed. Coe					Ευ	ınic	e Ma	ae	Brac	lford	
maryland	and and sum		19a. Informant's Name/Relationsh				g Address (Street							_
	Health tem 27 other tr		Betty Coe  20a. Method of Disposition	Wife	20b. Pl	ace of Dispos	L Dalton					ry Land tion - City or Tov		7
Ē	Pages nent of int: If it iry or o		1 ▼Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp			emetery, cren stern	cem.	· 1	2-6-	04 F	Ra 1 +	imore.	Md	
gaitimore,	permit. Pages Department of I Important: If to any injury or o		21. Signature of Funeral Service L	Estep	,	22	Name and Address	ss of Facility	v	C3000			ma.	
П	205 2 3		Hours m	Sley	45	13	tep Bro	aw"P1	ace	,Baltin	ore	., Md. 2	1217	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused inly one cause on each lin	1/		N		cardiac o	r respiratory arres	st,		Approximate Interval Bet Onset and I	ween
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a	V	ience of):	Deprent	7.7						
	Examiner		Sequentially list conditions,	b										
7	bet nsit	niner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	t consequ	ianca of):								
4)	execu in and ial-tra	Examin	that initiated events resulting in death) Last	C. Due to (or as a	consequ	ience of):								
2/80	icate be executed physician and s the burial-transit	dlcai	ţ	d										
ο ο ο		/Med	IF FEMALE:	23c. If yes, outcome of	of propper	204								
0	death certiting eattending point of for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)				230	d. Date of deliver Month		/ear
j.		hysi	9 Unknown	9□ Unknown										
S,	requires that the der neen signed by the a hould be detached for	by	Part II. Other significant condition	is contributing to death bu	t not resu	Iting in the un	derlying cause give	en in Part I.				contribute to the		
coras	pead beed shou	eted								· · · · · · · · · · · · · · · · · · ·		No 3 Proba		
d)	e la has	Completed								24a. Was an autopsy perform	ed?	death?	pletion of ca	ivailable iuse of
	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one	No	1 □ Yes 2	2 DNO-	
<u> </u>	Physician: this certific	ို	1 ☐ Yes 2 ☐ No	Hospital: 1  Inpatier		ER/Outpatient		4 CPINUI		ne 5 🗆 Residen				
	ding F h. After funera	tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		Year)	28b. Time of Injury	28c. Injury Work	/at <br Yes 2 □ N		28d. Describe how	injury o	ccurred		
DIVISION	Atten ar deat ector: by the	Certification:	2 Accident investigated as Suicide 6 Could not determine a company of the could not be	ot be	ry - At hor	me, farm, stre				28f. Location (Stre	et and N	lumber or Rural	Route Numb	ber,
5	ital or rs afte raf Dir led in	Cert	4   Horricide	bullaing, etc.	. (Зреспу,	) 			ı	City or Town,	State)			
	To the Hospital or Attending Physician: whith 24 hours after deals.  To the Funeral Director: After this certific completely lilled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best o	examınatı	vledge, death ion and/or inv	occurred at the timestigation, in my of	ne, date and pinion, deat	place, a	and due to the cau ad at the time, dat	se(s) an e and pla	d manner as sta	ted. the cause(s)	
	ro the within ! ro the comple	Med	29b. Signature and title of certifier	and manner stat	. <del></del>		29c. License					igned (Month, D		
	->-0		Paymond Mr	this mo			10471	83			2/3	104		
	6		30. Name and address of person w			23а) (Туре, Р	DA76 Print) Co Ria							
	T	á	31. Date filed (Month, Day, Year)	25 Mai SN 32, Registra	r's Signat	-	00 Ria	Shown	MD					
	Sta Registr	_	FFR 1 0 20			pa	don't	5						

			1 - For State Ragistrar	State of Ma	ryland / Dep <i>Ce</i>	artment <i>rtificate</i>			ind M	lental Hy	giene Rag. No.	20	04	036	6
	<b>-</b>		1. Decedent's Name (First, Middle, Las	t)						2. Date of De	ath			3. Time of De	ath
	Physic /Medi		JAMES	E	C	DLITE	R			FEBRU/	Jay Jay	1 2	Year DD4-	12:10	AM
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of	Death		4c. (	County o			
			Northwest Hospita					1stow				11ti			
н	Funeral		5. Social Security Number 6. Social Security Number 6. Social Security Number 9. Social Security	7. Age DM 2□F	(In yrs. last birthday, 62 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Feb. 2	th ay, Year)	1 ,	9. Birthi	place (State or F ntry) h Carol	oreign
	Director		Usual Residence of Decedent	-	02 113.					Feb. Z	5 194	+ L   I	Nort	h Carol	1na
	ytand		10a. State 10b. County		10c. City, Town or L	ocation								Od. Inside City I	imits
	Mar Me-f st	io	MD N/A		Baltimore									1 XYes 2	□No
	th the	Director	10e. Street and Number			10f. Zip (	Code				10g. Citíz	en of Wi	hat Cou	ntry?	
	23a	Ta I	4523 Mannasota Ave	nue		21	1206				Ü	JSA			
	within 72 hours after death with the Maryland one. than "neturef", or items 23a or 28a-1 show the Maryland Existinate; ust be notified at	Funeral	11. Marital Status	t2. Was Decedent Ex Armed Forces?	ver in U.S. 13.	Was Decede	nt of His y Cubar	panic Origi n, Mexican,	in? (Spe Puerto	cify Yes or No Rican, etc.)	)- 1		- Americ	an Indian,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ZY No If Yes, Give		1 ☐ Yes 2						Specify:			
ခို	ture	edk	15. Decedent's Ed	Year or Dates:	162 Doco	dont's Heurl	0001100	tion							
15	n ne	Completed	(Specify only highest grad	de completed)	(Give	dent's Usual kind of work DO NOT use	done di	uring most o	of worki	ng	16b. Kin				
212	J with	E	Elementary/Secondary (0-12)	College (1-4or 5+		dial E	Ingi	neer			Scho			ublic em	
פַ	othe vent,	0	17. Father's Name (First, Middle, Last)						's Name	(First, Middle,					
/lai	uld b Wents rrked ritice	To B	James Morris				.	Annie	Col	ter					
a.	2 sho and Is me		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (	Street a	nd Number	or Rura	l Route Numbe	er, City or	Town, S	tate, Zip	Code)	
≥ ~	and ealth m 27 her tr		Annie Colter Morri	.s - Mother		- Carlo		venue	, Ва	ltimor	e, Ma	ryla	and	21215	
O.	ges 1 t of H ff ite or otl		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name matory or oth	a of er place			ate			-	wn, State	
Ë	tmen tent:		' 4 ☐Donation 5 ☐ Other (Specify		Mt. Carme									Marylan	d
Baltimore, Maryland 21215-0036	permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23s or 28s-1 show any injury or other treumatic event, if ite Madical Exercitive 1: ust be notified at once.		21. Signature of Funeral Service Licens	Wist						e Fune: enue,				, F.A. D 21229	
			23a. Part1. Enter the disease, or composhock, or heart allure. List only of	lications that caused the cause on each line	ne death. Do not ent	er the mode	of dying	, such as ca	ardiac o	r respiratory ar	rest,			Approximate Interval Between	n
J	Physician		Immediate Cause (Final disease or condition	. CEP	TICEMI	A.								Onset and Dea	th
	/Medical Examiner		resulting in death)		consequence of):	^					-	-			
	Lxammer	_	Sequentially list conditions,	DA	Eumo	NIA									
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (of as a	consequence of):	SOLT.	0			207					
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (o as a	consequent e of):	BTIC	- 3	yorch	VOY	ne			- 1		
8760,	icate be executed physician and s the burial-transit	ä						I.							
687	ficate p physics the	edicai		d											
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy						23	d. Date (	of delive	D.	
Ď.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at tir		Ectopic preg Other (spec					23	Month		Day Year	
о. О	that the deatled by the atte	hys	9 □ Unknown	9□ Unknown											
S,	res that signed to be det	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cau	se giver	in Part I.		23e. Did to	bacco use	contrib	ute to th	e cause of death	1?
Records,	w require been si should b								_	1 □ Y	es 2.1	No 3	☐ Proba	ably 4 □Unkr	own
ပ္မ	e law r has be je 2 sh	ple								24a. Was		24b. We	re autop	sy findings avai	lable
_	(G CT	Completed								autop perfor 1 Yes		dea	th?	ipletion of cause 2□ No	) Of
Vıtal	Physicien: The ribis certificate ha ral director, page	Be	25. Was case referred to medical examiner?					26. Place of	f Death	(Check only or					
5	Physi this o	ဥ	1 tes 2 140	lospital: 1 Inpatient	2 ER/Outpatien		Other	4 LI Nursi	ing Hom	e 5 ☐ Resid	ence 6[	_Other	(Specify	)	
	ding F h. After funer	lon	27. Manher of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury		. Injury a Work?			8d. Describe h	ow injury o	occurred			
<u>s</u>	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	00-01		М		es 2∐No							
=	al or Attendate after death a Director: d in by the	Certification;	4 ☐ Homicide determined	building, etc.	- At home, farm, stre (Specify)	et, factory, c	office		2	Bf. Location (S City or Tow	treet and l n, State)	Vumber (	or Rural	Route Number,	
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sician: To the best of oner: On the basis of each	camination and/or inv	occurred at restigation, in	the time my opir	, date and p	place, ar	nd due to the c d at the time, d	ause(s) ar	nd manne ace, and	er as sta I due to	ited. the cause(s)	
	vithin o the omple	Me	29b. Signature and title of certifier	and mainlet state	<u>.                                    </u>	29c. L	icense r	number		2	29d. Date s	signed /A	Month. C	ay, Year)	
	- 5 - 0		A A	Man.		7	711	397	7		1 -	3 30 (//	i		
	4	-	30. Name and address of person who co	mpleted cause of dear	th (Item 23a) (Type (	Print)	17	<u> </u>		\ Y	cosua	my		2004-	
				301 Hospita	Prive	lolon B	Turn	115. M	w.	21861		•			
F	Sta	e	31. Date filed (Month, Day, Vear)	32. Registrar's		9			- V. J.	21001					
	Registra	ar	TTD 4 0 2008	General	19 A	2000 8	1								

			1 - For State Registrar	State of Marylan	id / Depa <i>Cei</i>	artment of H rtificate of I	lealth and M <i>Death</i>		giene 2 (	004	03668
В	hysici	an	1. Decedent's Name (First, Middle, Las			<del></del>		2. Date of Dea Month		Year	3. Time of Death
	/Medic		Alice Mannin					Februar	^y 6,20	04	3:25P M
E	xamin	ner	4a. Facility Name (If not institution, give Uakcrest Care Cent			4b. City, Town, or Parkvi	r Location of Death			y of Death	
Fu	neral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	timor	e lace (State or Foreign htry)
	ector		214-14-0034	<sup>□™</sup> %∀₹ 101	Yrs.	Months Days	Hours Min.	June 8,	1902	Ohio	try)
and			Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1.	0d. Inside City Limits
Mary	pall	tor	Maryland Baltimor	re Par	kville						1 □ Yes 2 □ No
th the	100	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of	What Coun	
ath w	in the	rai	8800 Walther Blvd			21234			USA		
ter de	Lieu	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ⚠ No	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ ick, White, i	
urs af	E SE	by	3 XXVidowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2 <b>X</b> XNo	Specify:		Specif	ty: Wi	nite
d Z 1 Z 13-0050 filed within 72 hours after death with the Maryland Hygiene, Hygiene 13a a 25a 4 and when when then and a standard and and a standard a standard and a standard a standa	in in	Completed	15. Decedent's Edu (Specify only highest grad	ication (e completed)	(Give	lent's Usual Occupa	durina most of workii	na	16b. Kind of B	lusiness/Inc	Justry
within ane.	4	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	1)		Г.	فالممالة	:
2 should be filed within and Mental Hygiene.	ent, il		17. Father's Name (First, Middle, Last)	5+		acher	18. Mother's Name	(First, Middle, I		ducati	ton
uld be Mental	tic ev	To Be	Walter Pierce Ma	nning			Cynt	hia Mar	y White	9	
2 should and Men	nen z'r is markeu birler ineu men y driens zoa or zea-i snow other treumatic event, if a Madical Examiner mast be natified at		19a. Informant's Name/Relationship (T)	γρ <b>e</b> , Print)	19b. Mailin	g Address (Street a	and Number or Rura	l Route Number	, City or Town,	State, Zip	Code)
t and tealth	thert		Elaine M Cook  20a. Method of Disposition	POA	3508	Hampstea sition (Name of	d Mexico	Road Ha	mpstea.	1 Md 2	1074
Pages ment of h	eny injury or other treu		XXBurial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, cren	natory`or other place	θ)		20c. Location		
permit. Page Department of	iniur		'4 ☐ Donation 5 ☐ Other (Specify) 21 - gnature of Funeral Service Licens			Cemetery	2/9/0 ss of Facility Mito	4	Hydes,	Maryl	and
	eny ir		Lanny Dresk	in Kenak	2	(	6500 York Ro	ad Baltin	nore. Mar	rvland	21212
			23a. Part1. Enter the disease or compleshock, or heart failure. List only of	ications that caused the death ne cause on each line.	. Do not ente	er the mode of dying	g, such as cardiac o	r respiratory arre	est,		Approximate Interval Between
Priysi	ician dical		Immediate Cause (Final disease or condition resulting in death)	A S C	こくり						20 yr 1
Exam			f	Due to (or as a consequ	uence of):						•
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):					-	
ecuted	transi	Examiner	that initiated events resulting in death) Last	o							
be ex	the burial-transit		in double, Educ	Due to (or as a consequ	ience ot):						
or Attending Physicien: The law requires that the death certificate be executed that death certificate be executed that death. On the this certificate has been stoned by the attending physician and Director: After this certificate has been stoned by the attending physician and	mo	edicai		J							
eath certif	for use	an/M	23b. Yras decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy				te of deliver	,
ne dea	hed fo	Physician/M	in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown	4□Pregnant at time of de 9□ Unknown		Other (specify)			Мо	nth [	Day Year
that the	be detached f		Part II. Other significant conditions col	ntributing to death but not resu	Ilting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to the	e cause of death?
quires		ed by	Chromic 1	or onclint?				1 □ Ye	s 200 No	3 🗌 Proba	ıbly 4 ∏Unknown
law requ		Completed						24a. Was ar		Were autop	sy findings available
The ate h	ral director, page 2	Com						autopsy perform 1 Yes 2	ned?	death? ∐Yes 2	npletion of cause of
icien	rector	Be	25. Was case referred to medical examiner?	lospital:		104.	26. Place of Death				
Phys	eral di	٦: <u>٦</u>	1 ☐ Yes 2 ☐ No ☐ ☐ 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA	4 Nursing Hom	e 5 ☐ Reside 8d. Describe ho			
ath.	e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	? ′es 2 □ No		, ,		
or Atte	n by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	8f. Location (Str City or Town		er or Rural	Route Number,
Hospitel or 24 hours at Funeral D	pellij		29a. Certifier 12 Certifying Phys	ninian. To the heat of my know	uladas dasti						
To the Hospitel or Attending is within 24 hours after death. To the Funeral Director: After	letely	Medical	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	viedge, death ion and/or invi	estigation, in my op	e, date and place, at inion, death occurre	nd due to the ca d at the time, da	use(s) and ma ite and place, a	inner as sta and due to t	ted. the cause(s)
To the within 2	comp	M	29b. Signature and title of certifier	10.0000		29c. License	number	29	d. Date signed	(Month, D	ay, Year)
0/			Millio W	- Mosson		D3	10197	1	elver	7	2004
0			30. Name and address of person who co			1 10	en MVJ	Bulhn	W IM	02	( 234.
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat		00 0-01 ()	- Chil. C	y == ( \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	10 101	11 0	
Re	egistra	ar	rep 1 0 2004	Brown St	STORA .	Se )					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EBRUARY 6. **Physician** Ž7104 7:30 FM Peggy J. Dear /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 20, 1928 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 215F 220-24-7718 75 Maryland Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits 10a. State Show s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. I then the Table of 186-18 show often transition of the transmit event, the Musical Exteriment and the multiple and other transmit event, the Musical Exteriment and the multiple and other transmit event, the Musical Exteriment and the multiple and other transmit event, the Musical Exteriment and the multiple and the second 1 Yes ZX No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Rumford Drive Unit 101 21228 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Specify: White If Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fitternent of Health and Mental Hytant: If item 27 Is marked oth Be Carville Earle Viers, Sr. 2 Anna Dorothy Lay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dear (Son) 9804 Old Mill Road Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-10-2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licensee) 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. Dema / 1630 Edmondson Avenue Catonsville, Maryland 21228 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician resulting in death) /Medical Due to (or as a consequence of): CORONARY ARTERY BYPASS SURGERY **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner death certificate be executed use as the burial-transit CORONARY ARTERY DISEASE that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Day Year 5 Other (specify) signed by the a P.O. 1 Yes 20 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2. No 3 Probably 4 Unknown HEPARIN INDUCED THROMBOCYTOPENIA page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 242 No certificate 2□ No 1 ☐ Yes 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Dippatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М or Attendiate after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospitel Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of costifier D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Fegistrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204-7582 KH00 M. D. 31. Date filed (Month YP 0 2004 State CAR. Registrar

		1 - For State Registrar	State of Maryland / Depa		ental Hygien	e 2001, 0367
	sician	Decedent's Name (First, Middle, Last)     Agnes Irene				ay Yeer 3. Time of Death
à .	edical miner	4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Death Columbia	Februar	c. County of Death
Fune Direct		5. Social Security Number 6. Sex 184020-6484	7. Age (In yrs. last birthday) M 2X F 83 Yrs.	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Year April 22,	Howard County  9. Birthplace (State or Foreign Country) 1920 New York
death with the Maryland ms 23a or 28a-f ahow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard  10e. Street and Number	10c. City, Town or Lo Columbia	10f. Zip Code		10d. Inside City Limits 1 ☐ Yes 2 No itizen of What Country?
	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐Yes 2X☐No	21045 Was Decedent of Hispanic Origin? (Specify Secretary Cuban, Mexican, Puerto R		J.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
filed within 72 hours after Hygiene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)  (Give life. L	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g	Kind of Business/Industry
		17. Father's Name (First, Middle, Last)	N/A Homes	maker  18. Mother's Name  Julia Ko	(First, Middle, Maide	er own home
ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty)		ng Address (Street and Number or Rural Tamar Drive Colum	Route Number, City nbia, MD	or Town, State, Zip Code) 21045
Deficiency of the properties o		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place) ort Crematory 2/7/0	200. 2	ocation - City or Town, State Xandria, Virginia
permit. Pages Department of Important: If it	SUCE.	21. Signature of Funeral Service License	22 W.	Name and Address of Facility itzke Funeral Homes 555 Twin Knolls Roa	inc.	oia, MD 21045
Physicial Physician and Physic	er	23a. Rant1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do not ente		respiratory arrest,	Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Attent this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
requires that een signed by	ed by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the un	nderlying cause given in Part I. Classes method		use contribute to the cause of death?
in: The law re ificate has bei	e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	on: To B	examiner? /	ospital: 1 Inpatient 2 ER/Outpatient  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at 28 Work?	Check onlone  5 X Residence  Id. Describe how inju	
al or Attend s after death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	M 1 Tes 2 No	f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
he Hospit in 24 hours he Funera pletely fille	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, death ler: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, an estigation, in my opinion, death occurred	d due to the cause(s I at the time, date and	and manner as stated. d place, and due to the cause(s)
Tot Tot Com	\	29b. Signature and title of certifier	Milles MD	29c. License number	29d. Da	Anum 6 2004
_	ソ	GARY MILLES	mpleted cause of death (Item 23a) (Type, F	Print) RITER PORTUS, CCL	UMBIA	MO.
	State istrar	31. Date filed (Month, Day, Year) FEB 10 200	32. Tegistrar's Signature	and the		

			1 - For State Registrar	State of Maryla			f Health a of Death		jiene 2001	+ 03671
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, L TACE  4a. Facility Name (If not institution, gi	DOUGHERT ve street and number)	y (1-1	4b. City, Tow	m, or Location o	2. Date of Dea Month FED	th Day Year 05 200 4c. County of Dea	4 2:40 PM
	Funeral Director				s. last birthday) 92 Yrs.	If Under 1 Your Months Da	ear If Under 2	24 Hrs. 8. Date of Birth Min. (Month, Day) Aug 5,	Year) C	thplace (State or Foreign country)
9	72 hours after death with the Maryland netural', or items 23e or 28a-f show dical Evand writings by Indiffical at	Funeral Direc	10a. State 10b. County Maryland Howar  10e. Street and Number 6400 Beechfie  11. Marital Status 1 Never Married 2 Married	d  1d Avenue  12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 図 No	1	idge 10f. Zip Coo	1075 of Hispanic Orig Cuban, Mexican,	gin? (Specify Yes or No- Puerto Rican, etc.)	Og. Citizen of What C  U • S • A	erican Indian,
Baltimore, Maryland 21215-0036	filed within Hygiene. other than "	e Completed by	3 ☑ Widowed 4 □ Divorced  15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 8  17. Father's Name (First, Middle, Las	cade completed)  College (1-4or 5+)	16a. Deced	lent's Usual Oo kind of work do OO NOT use re	ecupation one during most tired)	of working	Specify:  16b. Kind of Business  Own Home  Maiden Sumame)	,
re, Marylan	1 and 2 should Health and Mer em 27 is marke ther treumatic	ToBe	Samuel Birely  19a. Informant's Name/Relationship  Grace Hickey (Da  20a. Method of Disposition	ughter)	6400	Beechf	Ann reet and Number	ie Trieschm ror Aumi Route Number e. Elkridge	an ; City or Town, State,	21075
Baltimo	permit. Pages Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	(fy) Me	cemetery, cremetery, cremeter, cremetery, cremetery, cremetery, cremetery, cremetery, cremeter, cremet	lge	Idress of Facility	2-9-2004 1	Elkridge,	Maryland
1	Physician /Medical Examiner		23a Part1. Enter the disease, or core shock, or head failure. List only immediate Cause (Final disease or condition resulting in death)		Ath. Do not ente	er the mode of	dying, such as o		est,	Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse						
P.O. Box 68	death certifi e attending I ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3□	Ectopic pregna Other (specify			23d. Date of de Month	livery Day Year
	requires thaten seen signed	by	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	derlying cause	given in Part I.	1 🗆 Ye		robably 4 Dunknown
Vital Records,	The lar	e Completed	25. Was case referred to medical				26. Place	24a. Was ar autops: perform 1 Yes 2	ned? death?	utopsy findings available completion of cause of
of	ding Phys h. After this funeral di	ation; To B	examiner?  1 Yes 2 No  27. Mann of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. l	Other	sing Home 5 Reside 28d. Describe ho	nce 6 Other (Spe	cify)
É	P de le le	al Certification;	3 Suicide 6 Could not to determined	building, etc. (Spec	nowledge, death	occurred at the	a time, date and	City or Town	use(s) and manner as	stated
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only one) 2 Medical Exe	miner: On the basis of examinand manner stated.	nation and/or inv	estigation, in m	ny opinion, death	occurred at the time, da	ate and place, and due	to the cause(s)
	1		30 Name and address of person who	completed cause of death (Ite	m 23a) (Type, F		18195 HE10	COHOS AVE	BALTI	MD 2120F
	Sta Registr	_	31. Date filed (Month, Day, Year)  FFR 1 0	32. Registrar's Sign		last.			1	

		1 - For State	State of Maryland /	Department of Health and I  Certificate of Death	Mental Hygiene Reg. No	21004 03072
		1. Decedent's Name (First, Middle, La	st) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Commodition Dodain	2. Date of Death Month Da	3. Time of Death
Physi /Med	ician dical	Kelly	Dillon			8, 2004 5:51 P <sup>M</sup>
Exam		4a. Facility Name ( not institution, giv		4b. City, Town, or Location of Death	1 40	c. County of Death
		200 block North  5. Social Security Number 6. S		Baltimore birthday) If Under 1 Year   If Under 24 Hrs.	B. Date of Birth	9 Birthplece (State or Foreign
Funera Directo			M 20F 07	Yrs. Months Days Hours Min.	Dec. 15	966 Maryland
and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	,	10d. Inside Çity Limits
Marylan f ehow	ğ	100	0 13	timore		1 Yes 2 No
th the or 28a s nutti	irec	10e. Street and Number	. 1	10f. Zip Code	10g. C	itizen of What Country?
be filed within 72 hours effer death with the Maryland tal Hygiene. Id other then "natural", or fleme 23a or 28a-f ehow event, the Medical Examinar must be routilled at	Funeral Director	943 W. Lexi		21000	145	H Same American Indian
ter de	une	11. Marital Status  1. Never Married 2 Married	12 Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Rece - American Indian, Black, White, etc.
ral", or	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 12 No Specify:		Specify: BIACK
natur	Completed	15. Decedent's E (Specify only highest gr		<ol> <li>Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)</li> </ol>	king 16b. F	Kind of Business/Industry
within then	amo	Elementary/Secondary (0-12)	College (1-4or 5+)	Warehouseman	F	actory
e filed al Hyg	BeC		1 1 1/2		ne (First, Middle, Maidel	n Sumame)
2 should be filed with and Mental Hygiene. Its marked other their aumatic event, their	101	MUISIANI O. F	tenaricks	Loretto	L VIIION	= = 1= .
partitions, War yield A. I. I. I. J. 1900.  parmit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene.  Importent: If item 27 is marked other then "natural", or iteme 23s or 28s-1 ehow any injury or other traumatic event, the Medical Examinat must be nutitied at		19a. Informant's Name/Relationship	- Mother	9b. Mailing Address (Street and Number or Ru	St. Bolt	or Town, State, Zip Code)
Department of Health Importent: If item 27 any injury or other tr		20a. Method of Disposition	20b. Place	o of Disposition (Name of etery-crematory or other place)	Date 20c. L	ocation - City or Town, State
Peges nent of 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemoval from State   A A	Carmel Cemetery 2-1	16-04 Dur	ndalk, MD
permit. Departr Imports eny inju	DUCE.	21. Signature of meral Septide Lice	9586	22. Name and Address of Facility	04 16	142 0000 0010
0050	a	23a Party Starthe sease or con	inlications that caused the death. O	DO not enter the mode of dying, such as cardiac	or respiratory arrest	Iton Pass Bosto, Mb
Physicia		shock, or eart failure. List only Immedia: use (Final disease or condition	one cause on each line.			Interval Between Onset and Death
/Medica	al	resulting in death)	Due to (or as a consequence			
Examine		Sequentially list conditions,	b	- 0		
ted nsit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	Co Jīj.		
execu execu en and rial-tra	Exar	resulting in death) Last	Due to (or as a consequence	ce of):		
cate be executed by sicien and the burial-transit	dical		d.			
certific nding pluse as 1	Med	IF FEMALE:	23c. If yes, outcome of pregnancy			004 0-1
death of atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
by the	Physician/Me	9 Unknown	9□ Unknown	a man an		
The could us, F.C. DOA 00100,  The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burran-transit	출	Faith. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.		use contribute to the cause of death?
vequires i been signe should be	Completed				24a. Was an	24b. Were autopsy findings available
he lav e has	amo				autopsy performed?	prior to completion of cause of death?
ian: ] ortifical ctor. p	BeC	25. Was case referred to medical		26. Place of Dea	1 Yes 2 Neath (Check only one)	o 1 XYes 2 No
Physician: r this certificaral director.	P	1⊠Yes 2□No				650 ther (Specify) At scene
nding Phy ath. r: After thi	ţon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Time of linjury at Work?  SULAPM 1 □ Yes 2 No	Subject wa	· · · · · · · · · · · · · · · · · · ·
Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Chlomicide determined	De 28a Place of Injury At home			and Number or Rural Route Number.
ital or rs after all Dir	Cert	4 Storillorde		Alley		N, Amily & MO
To the Hospital or Attending Physician: The law requires that the death certifications of the Hospital or Attending Physician: The law requires that the death certifications after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical			dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu		s) and manner as stated.
ro the vithin of the omple	Me	29b. Signature and title of certifier	and mainer stated.	29c. License number	29d. Da	ate signed (Month, Day, Year)
F > F 0		Jasha ? H	eenson MD	O,C.M.E.	Jan	uary 29, 2004
1		30. Name and address of person who		a) (Type, Print)	Raltimoro	, Maryland 21201
	State	Of Date (It of (March Day Vers)	M. D.  32. Begistrar's Signature		, ватешоте	, nary rain 21201
	State strar	1 A 1	2004 1 300000 1	Acreste)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 205 PM 1005 20 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore John Hopkins 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 ☐ M 2 ☐ F 10a. State 10b. County 10c. City, Town or Location 10d. Inside Oity Limits 1 Yes 2 No MD SAUTIMURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/205 BOND 001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Newer Married 2 Married BLACK If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DONOT use retired)

HOUSE LEPER Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Nan (First, Middle, Last) 18. Mother's Name (First, Middle, Maide. URNEU GERTRUDE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 AUGHTER 4612 BALTO, MO 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BATIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility VAVEHN C. GREENE FUNERAL TONE 21. Signature of Funeral Service Licenses RUAD BATTIMORE, MO 21212 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic Branch of):

Due to (or as a consequence of): Nine Days if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hypertension 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the death certificate be executed and the attending physician a hed for use as the burialo. detached signed by t d be detact as been signal has page certificate Division of Vital director, After this To the Hospital or Attending To the hosping within 24 hours after death.

To the Funeral Director: Aft

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ahow

or Items 23a

\*natural',

s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than

permit. Pages i Department of P Important: If Ite any injury or otl once.

**Physician** 

/Medical Examiner

Pages 1 and 2

Director

Funeral

à

Completed

Be

Examiner

Physician/Medical

à

Completed

Medical Certification;

other traumatic event, the Madical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Registrar

29b. Signature and title of certifier Medica

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

KES - 060

Bultimore MD 21287

30. Name and advress of person who completed cause of death (Item 23a) (Type, Print)

tebruary 02

Telly Ali Medow 31. Daye filed (Month, Day, Year)

(Check only one)

e Johns Hopkins Hospital 600 N Wolfe St 32. Registrar's Signature FEB 1 0 2004 And a

**ORIGINAL** 

			For State Registrar	State of Ma	ryland	l / Depa <i>Cei</i>	artment of F tificate of i	lealth and N Death		giene 2	004	03674
	-1		Decedent's Name (First, Middle, Last	it)					2. Date of De.	ath	V	3. Time of Death
	Physici		VINCENT		DiM	AGGI0			FEBRUA!	RY 6, 2	Year 2004	0715 M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death		4c. Coun	ty of Death	
			HERITAGE HARBOR	REHABILITAT	CION	CTR	Annapo				NNE A	RUNDEL
	Funeral		Social Security Number     6. S.	7. Age	(In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthp	lace (State or Foreign
*	Director		062.16.0732	UM 2UF	91	Yrs.			JAN 27		SICI	LY, ITALY
	pug M	-	Usuel Residence of Decedent  10a, State 10b, County		10c. City.	Town or Lo	cation				1	0d. Inside City Limits
	Aaryli Feho	ō	MD ANNE AR	UNDEL	CR	OFTON						1 ☐ Yes 2 ☐ No
	28e-	Director	10e. Street and Number				10f, Zip Code		T	10g. Citizen of	What Cour	ntry?
	with Pe or									TICA		
	ns 23	Funeral	1603 EARLHAM AVE	12. Was Decedent E	ver in U.S.	. 13.1	21114 Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No	USA - 14. Ra	ce - Americ	an Indian,
·0	r Her o	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX	,	1		an, Mexican, Puerto	o Rican, etc.)	1	ack, White,	etc.
ဗ္ဗ	ef., o	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 □ Yes 2 □ No XX	Specify:		Spec	ify: WHI	TE
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow he Modical Examiner mast be motified at	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	ient's Usual Occup	ation during most of work	kina	16b. Kind of	Business/In	dustry
7	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+	)	life.	DO NOT use retired	1)				
7	filed w Hygier other th	ပိ	8 (5.116.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4			TRUC	K_DRIVER	18. Mother's Nam	o (Eine Middle	TRANSP		ION
ng	tal H	Be	17. Father's Name (First, Middle, Last)								unej	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel; or items 23e or 28e-f show any injury or other traumatic event, the Medical Exaministic natible notified at once.	To	GERIAMOLO DIMAGG			10h Mailie	- Address /Ctmat	GRACE and Number or Ru	PUGLIS		e State Zie	Codal
Nai	12 st h and 7 te n Iraun	19	19a. Informant's Name/Relationship (	•	- 3			AVE. CROF			п, зтате, гір	(C009)
	1 and 2 Health tem 27		JEROME A. DIMAGG  20a. Method of Disposition	10	20b. Pla				Date	20c. Location	- City or To	own. State
Baltimore,	Pages nent of I ant: If It	М	1 ☐ Burial 2 ☐ Cremation 3		PIN	metery, crer FILAWN	sition (Name of natory or other place MEM. PK	2/10	/2004	WELLWOO		
Ë	it. Partimer ritent njury		*4 ☐ Donation 5 ☐ Other (Specifical Service Liver		1 11	,		ss of Facility FI				
Ba	permit. Page Department Importent: If eny injury or once.		21. Signatur Fineral Service Lizer	The		4	26 CRAIN	HWY., S,	GLEN BU	URNIE,	MD 21	061
	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a	conseque	A-Sji~	6 *	ng, such as cardiac		rrest,		Approximate Interval Between Onset and Death
8760,	ficate be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
O. Box 6	The law requires that the death certificate has been signed by the attending bit age 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ Po 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal	death 3	Ectopic pregnancy Other (specify)	/			eate of deliver	ery Day Year
rds, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions of	ontributing to death but	t not result	ting in the u	nderlying cause giv	en in Part I.		obacco use co Yes 2□No	ntribute to th 3 ☐ Prob	ne cause of death?
Vital Records,		Completed							24a. Was autor perio 1  Yes		prior to con death?	psy findings available mpletion of cause of
/ita	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	nne)		
of/	Physic this c	٩	1 ☐ Yes 2 ☐ 490	Hospital: 1 ☐ Inpatien		R/Outpatier		4 Sessursing n	ome 5 Resid			y)
n C	Jing P	e e	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	Wor		28d. Describe	now injury occi	irred	
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	9				Yes 2 □No	20(1 1 1 1	2		10
Division	for Attence after death Director; I in by the	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	ne, farm, sti	eet, factory, office		City or Tox	vn, State)	nder or Hura	l Route Number,
ت	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1, □ Certifying Ph	ysician: To the best of	f my know	riedne dest	necurred of the tr	me, date and place	and due to the	cause(e) and a	nanner se e	lated
	24 hc 24 hc Fun etely	edical		niner: On the basis of and manner state	examination							
	o the	Me	29b. Signature and title of certifler				29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	F > F O		1 2 D D	M evens	>		03.	1036		2/7	12000	1
	1		30. Name and address of person wh	_		23а) (Туре.						
	7		Day 1 26	1. 0 -	5108		com may 1	rive Ch	14 her in	(1) J	1619	
Se.	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu		Span	61				

			. For	State of Maryland	/ Depa	artment of h	leaith and M	•	•	the second second second
			1 - State Registrar		Cei	rtificate of	Death	Re	g. No. & UUI	+ U36/5
	Physici /Medi		1. Decedent's Name (First, Middle, I	Lee Do	NV S	2		2. Date of Death Month Februar	Day Yeer	3. Time of Death 10:40 P M
	Examir		4a. Facility Name (If not institution, g	ive street and number)			or Location of Death		4c. County of Dee	
			Magnolia Center			Lanham			Prince Ge	
	Funeral Director	Ĕ	246-38-7306	Sex   7. Age (In yrs. las	ot birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 25,	Year) 9. Bird 1928 Nor	thplace (State or Foreign ountry) th Carolina
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Many f aho	ō		Wash	inata	n, D.C.				1 Yes 2 No
	the 28s	rec	10e. Street and Number	Wasii	Liigto	10f. Zip Code		10	g. Citizen of What Co	ountry?
	3a or	by Funeral Director	3719 30th Place,	NE		200	18		U.S.A.	. 2
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.S.	13.		dispanic Origin? (Spe an, Mexican, Puerto F		14. Race - Ame	erican Indian,
9	or Ita	교	1 Never Married 2 Married					Rican, etc.)	Black, Whit	e, etc.
8	ral', c		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify: B1	ack
50	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f ahow ta Medical Exeminar med be notified at	Completed	15. Decedent's (Specify only highest of	Education rade completed)	(Give	dent's Usual Occup	during most of working	1	6b. Kind of Business/	findustry
2	ithin ne.	npl I	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)	Mo	ontgomery	•
2	filed wil Hygien other th				Mai	ntenance			ıblic Scho	ol
and and	be fi	Be	17. Father's Name (First, Middle, La: Tom Davis	61)			18. Mother's Name Annie Ru		laiden Sumame)	
ž	2 should be and Mental Is marked o	ို	19a. Informant's Name/Relationship	(Time (Irint)	405 44.00		1			
Maryland 21215-0036	O1 00 161		Margaret Davis/W	ife :	3719	30th P1.	, NE, Wash	ington.	D.C. 2001	Zip Code) 8
စ်	1 and 2 Health tam 27		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	. Di	_	Oc. Location - City or	
Baltimore,	Pages nent of I		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec	⊟Removai from State	-	natory`or other pla o1n Cemed	tery 2-10-		entwood, 1	
量	artme ortar injur		21. Signature of Funeral Service Lic	-		. Name and Addre	an of Facility			
ä	permit. Departm Imports any inju		11/4	T love			For		n Funeral	
	*		23a. Part1. Enter the disease, or co	mplications that caused the death.	Do not ent	or the mode of dying	nsburg Rd.	, Brentw respiratory arres	700d, MD 2	0 7 2 2 Approximate
10	e lies		shock, or heart failure. List on Immediate Cause (Final	y one cause on each line.			0,000		7	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequent	-	Lan	OVV	2000		
	Examiner			Due to to as a consequent	1.					
V		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	ice of).					
1	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
9	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):					
3760	ate be nysicia he bur	Ical		d						
89	leath certificate attending phys I for use as the	Med	IF FEMALE:							
Вох	death ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1☐Live birth 2☐ Fetal de	eath 3□	Ectopic pregnancy	,		23d. Date of deli	,
o.	O O O	Physician/Medl	1 Yes 2 No	4☐ Pregnant at time of deat 9☐ Unknown	th 5	Other (specify)			Month	Day Year
٦.	The law requires that the de ite has been signed by the a page 2 should be detached to	P.	Part II. Other significant conditions	contributing to death but not regulting	ng in the ur	adorhina agusa au	ens in Part I	230 Did tobo	acco use contribute to	the course of death?
ds,	signe d be	1 by	, at the other digital contains	contributing to dodar but not result	ing in the th	idenying cadse giv	en in Fait i.		; 2□No 3□Pro	A
Ö	w requir been si should	Completed						-		
360	e law has l	mpi						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u>=</u>								perform 1 Yes 2	ed? death? XNo 1 ☐ Yes	20X No
Vital Record	Physician: The law this certificate has l ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
ot	O - 'a	- To	1 ☐ Yes 2 X No 27. Manner of Death	1 Inpatient 2 EP	VOutpatien 3b. Time of	1 3 DOA	4 X Nursing Hom		ice 6 Other (Spec	cify)
o	ding h. After fune	to Lo	1 Natural 5 ☐ Pending	(Month, Day Yeer)	Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	8d. Describe how	vinjury occurred	
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could not	be 290 Place of laive. At home	a. farm. stre		-	Bf. Location (Stre	eet and Number or Ru	ral Route Number
<u>S</u>	after after I Dire	Certification:	4 Homicide	building, etc. (Specify)		out 1200019; 011100		City or Town,		7001074011001
	spite hours inara y fille	a C	29a. Certifier 1 Certifying F	hysician: To the best of my knowle	edge, death	occurred at the tir	ne, date and place, ar	nd due to the cau	ise(s) and manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	iminer: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death occurre	d at the time, dat	e and place, and due	to the cause(s)
	Within To the COMP	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Month	, Day, Year)
)	0/					11/4	2077		215	104
	VV		30. Na 10 - 10 - 10 of person wh	completed cause of death (Item 23	За) (Туре, І	Print) ALE	XAMOCE	E.3 -	DON'T	bun
	1		7676 New	Hom DShine	. Are	# mus	20 Ta	lamo	, Parle W	W 20912.
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis r's Signatur	е					

DHMH 17 Rev 1/2001

ORIGINAL

			1- For amend Item 27, per	State of Marylan	d / Depa Cei	artment rtificate	of He	ealth ar Death	nd Me	ntal Hygi	ene2 ()	04	03676		
ı	Physic	ian	Decedent's Name (First, Middle, Last)						2	. Date of Death Month	Day	Year	3. Time of Death		
	/Medi		Ruth Edwards							sanuary		004	10474 M		
	Examir	ner	4a. Facility Name (If not institution, give s					Location of 0		/	4c. County				
		100,000	5. Social Security Number 6. Sex	tal CENTEV	ast hirthday)	If Under 1		IS TO VV		Date of Righ	Balt				
	Funeral Director			M 200 F 81	Yrs.		Days		Min.	Date of Birth (Month, Day, US   07	(Par)	Goul	place (State or Foreign		
	72 hours after death with the Maryland natural, or items 23a or 28a-f show alicsi Examiner must be multified at		10a. State 10b. County	10c. City	, Town or Lo	cation						1	I Od. Inside City Limits		
	Mar	ģ	MD Battin	nore W	oodst	ock							1 ☐ Yes 2 ☐ No		
	or 28	ire	10e. Street and Number			10f. Zip C	ode			10	g. Citizen of W	hat Cour	ntry?		
	23a	ai	9801 Slalom	Run Drive			211	163			us	A			
	ier death with the Marylan items 23a or 28a-f show ret mast be netified at	Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decede f Yes, specif	nt of His y Cuban	panic Origin , Mexican, F	n? (Specif Puerto Ric	y Yes or No- an, etc.)		- Americ	can Indian, etc.		
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	1	1 ☐ Yes 2[					Specify:	0.			
S	d within 72 hours after upiene. giene. ir than "natural", or ite; Ire Medical Examire:	ed b	15. Decedent's Educ	Year or Dates:	16a Dagge	ient's Usual	Ossupst	ion.			25 16 1 - 1 - 1 - 1		ack		
15	n n	Completed	(Specify only highest grade	completed)	(Give	kind of work DO NOT use	done du	iring most of	f working	, "	6b. Kind of Bu	sinessin	dustry		
212	d within piene. r than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Prob	ation	0	Stick	-		5+ a	l x	no		
Maryland 21215-0036	ent,	Bec	17. Father's Name (First, Middle, Last)	7				-		irst, Middle, Ma	iden Sumame				
<u> a</u>	should be ind Mental i marked o umatic eve	10 E	Julius K	eggie				Yau	Llin	e 4	ouna				
lan	2 should be and Menta is marked raumatic ev	ľ	19a. Informant's Name/Relationship (Typ	. ,				nd Number o	or Rural R	oute Number,	City or Town, S	State, Zip	Code)		
	1 and Health em 27		Joyce Ann me	- Neill	980	Slal	(Jm	Run	Dr	. W00	dstock	K, 17	10 DII63		
ore	es 1 a of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		ace of Dispo metery, cren	sition (Name natory or othe	of er place,	)	Date		c. Location - (	,			
Baltimore,	permit. Pages Department of I Important: If it any injury or o		*4 □ Donation 5 □ Other (Specify)	K	nat	ark		2	12/.	2004 \$	lande	alls	town mo		
Sall	Depart Import any in		21. Signature of Funeral Service License	•	22	Name and	Address	of Facility	ene	Funera	( Su				
_	0 0 E € 0		23a. Part 1. Enter the disease, or complic	hu-	8	728	45	ety	ad	, Rand	allston	w,	mD. 21133		
	Physician /Medical Examiner	iner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to for as a consequence of the total for a consequence of the total for as a consequence of the total for a consequence of the consequence of the total for a consequence of the	sfinal								Approximate Interval Between Onset and Death		
68760,	death certificate be executed e attending physician and ad for use as the burial-transit			dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
Box	that the death certific ed by the attending p detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3□	Ectopic preg Other (spec					23d. Date Mont		ry Day Year		
	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions con-	tributing to death but not resul	lting in the un	derlying cau	se given	in Part I.		_	_		e cause of death? ably 4 MUnknown		
of Vital Records,	2 2	Completed								24a. Was an autopsy performe	d? de	ere autorior to con eath?	osy findings available inpletion of cause of		
<del>=====================================</del>	ician certif rector	Be	25. Was case referred to medical examiner?	ospital:	-0.00					heck only one)					
ō	Physician: r this certifica ral director, p	7	1 Yes 2 No	1 Inpatient 2 □ E	R/Outpatient 28b. Time of		Other:	4 🗀 1401311		5 Residence			)		
S C	ding h. After fune	tion	1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		. Injury a Work?	ıı ıs 2 □ No	1	Describe how	injury occurre	d			
-	a or Attending after death. I Director: After d in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury - At horn building, etc. (Specify)	ne, farm, stre			is 2   NO		Location (Stree City or Town, S		or Rurai	Route Number,		
*	To the Hospital or Attending Physician: The lywithin 24 hours after death.  To the Funeral Director: After this certificate he c, mpletely filled in by the funeral director, page	edical	(Check only one)	er: On the basis of my know and manner stated.	neage, abath on and/or inv	estigation, in	me time, my opin	, date and pi nion, death o	nace, and occurred a	due to the causet the time, date	se(s) and man and place, ar	ner as sta id due to	ated. the cause(s)		
	Tot Tot	Σ	29b. Signature and title of certifier			29c. L	icense r	number			Date signed		**		
•	/		Many gr	y, amp			DOC	10051	67	Je	Rugay	26	, 2004		
	5		30. Name and address of person who con	npleted cause of death (Item :	23a) (Type, F	Print)				uvi a o	Pa	ndai	1,2004 Ustown,		
			rayjoy Meia Mo	- 63		ibil C	dille	1 0	1d 60	UVI C	24	May	yearlo		
	Sta Registr		31. Date filed (Morrie EB 14ear) 200	32. Registrar's Signatu	Ire .	ade							1		

				For State	State of M		partment of I ertificate of			giene 0	14 03677
				Registrar  1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea	ath	3. Time of Death
		Physici		OliFTON F	EUDA	Inks			Month FEBRUA		1: 88 PM
		/Medic Examin		4a. Facility Name (If not institution, give		7/11/	4b. City, Town,	or Location of Dea	th	4c. County of	Death
	1	Zami		SINAI HOSP	ITAL		BALT	MURE			
		Funeral Director		5. Social Security Number 6. Se 11 153-38-55/2	x IM 2□F	ge (In yrs. last birthd 54 Yrs	Months   Davs			y, Year)	3. Birthplace (State or Foreign Country)
		Du		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town o	Location				10d. Inside City Limits
		Aaryla   sho	ō	MO							1 ☐ Yes 2 ☐ No
		death with the Maryland ms 23s or 28s-f show rmust be notified at	Director	10e, Street and Number		TOACT	10f. Zip Code			10g. Citizen of Wh	nat Country?
		3a of		3025 OAKhil	1 Ave		212	02		USA	)
		after death w or items 23a miner must t	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Decedent of	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or No-		American Indian, White, etc.
	9	after or its	Ē	1 Never Married 2 Married	1 Pres 2 If Yes, Give		1 ☐ Yes 2 ☑ No		no moun, oto.,	Specify:	Plant
X	933	arat',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						DIACK
EVBANKS	21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryle it of Heatth and Mental Hygiene. If Item 27 is marked other than "natural" or Items 23s or 28s-1 shor or other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	ecedent's Usual Occu tive kind of work done e. DO NOT use retire	pation during most of wo ad)	orking	16b. Kind of Busi	ness/industry
5	12	within ene. then	ᇤ	Elementary/Secondary (0-12)	College (1-4or	5+)	myananc			Nors.	ne Klome
F	0	filed Hygi other	BeC	17. Father's Name (First, Middle, Last)		7.10	11/0 · iconc		ıme (First, Middle,	Maiden Sumame)	
5	lan	Mental Mental Med	To B	Clifton F. F.	Ubants	Se.		ARE	tha		
(TIELLEN	ary	shou and N	_	19a. Informant's Name/Relationship (7			ailing Address (Stree	t and Number or R	Tural Route Numbe	r, City or Town, Si	tate, Zip Code)
Ť	Σ	and 2 balth a n 27 ls		Yvonne E. 1	Eubant:		25 OAK	H:11 AU	e BAL,	Imore, n	5 21207
2	ore	of He		20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐	Removal from State	cemetery	sposition (Name of crematory or other pla	ice)	Date	20c. Location - C	ity or Town, State
	Ĕ	Pag ment ant: f		*4 ☐ Donation 5 ☐ Other (Specify	)	HR DUTC	- CUILCI	ery di	13.04	BALTIN	rore, mo
	Saltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral Service Licen	11		22. Name and Addr	ess of Facility V	. 0	reene Fe	neal Selvices
		70 5 8 Q	_	23a. Part1. Enter the disease, or comp	Leene	4 the death Densi	5128 Cil	Derty Ko		11stown,	m) 21133 Approximate
				shock, or hear failure. List only a	one cause on each I	ine.				1031,	Interval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)	d	- S M AU a consequence of):	cer l	LUNG CA	th CER		7 MONTHS
	4	Examiner				2 MONTHS					
			jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	0.	A STASES a consequence of	TO THE	BKAI			
		be executed ician and burial-transit	Examiner	that initiated events	c						
	oʻ	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
	8760,	ate hys	dicai		d						
	Вох 6	The law requires that the death certifics te has been signed by the attending ph vage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date Monti	the fact of the same of the sa
	P.O.	at the by th	hys	9 Unknown							
		es this igned be de	by F	Part II. Other significant conditions of			e underlying cause g	ven in Part I.			oute to the cause of death?
	ord	w requir been si should		CONGESTIVE	terret.	FAILURE					
	ec	law law las b	Completed						24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of ath?
	E H	: The	Co							2 □ No 1 [	Yes 2□ No
	Vit.	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			hor	eath (Check only o		(0. 11)
	o	Phys r this ral di	- To	1 Yes 2 □ No 27. Manner of Death	1 Ainpati		e of 28c. Inju	iry at	Home 5 ☐ Resid	lence 6 UOther low injury occurred	
	o	ading th. : Afte s fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	uý Year) Inju	ry Wo	ork? ]Yes 2∐No			
4	Division of Vital Records,	al or Atter s after dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, farm tc. (Specify)	, street, factory, office		28f. Location (5 City or Tow		or Rural Route Number,
		To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C			of examination and/o	eath occurred at the ir investigation, in my				ner as stated. d due to the cause(s)
_		To th withir To th comp	M	29b. Signature and title of certifier				se number			(Month, Day, Year)
		۸		* 4. 4X			KE	TØØØ		FEBRUA	ry 7, 2004
		A		30. Name and address of person who	completed cause of	death (Item 23a) (Ty		Hospita	L of	BALTI	MORE
		Sta		31. Date filed (Month, Bay, Year) 20	()4 32 Regist	rar's Signature	mel				

		ŀ	For State Registrar	State of	of Maryland		artment of H		nd Me		jiene 2	004	03678
			Decedent's Name (First, Middle	, Last)					2.	Date of Dea			3. Time of Death
н	Physicia		Russell	Lee		E11;	iott			Month Februai	Day	Year 2004	12:30P <sup>M</sup>
/Medio			4a. Facility Name (If not institution)		mber)		4b. City, Town, or	Location of				unty of Death	
	ZAGIIIII	·	2203 Stryker	Court			Timo	nium			Ва	altimo:	re
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
	Director		217-03-4948	1 M 2 □ F	86	Yrs.	Months Buys		No	ov 25,	1917		yĺand
	D >	. }	Usual Residence of Decedent  10a. State 10b. County		10c City	. Town or Lo	ocation						10d. Inside City Limits
	aryla ahov	5			100.0.0,								1 ☐ Yes 2 ☑ No
	he M	Directo		timore		Time	nium_ 10f. Zip Code			1	On Citizen	of What Cou	ntry?
	sth with the Marylan 23s or 28s-f show	늄	10e. Street and Number										Thu y i
	s 23	Funeral	2203 Stryker Co		edent Ever in U.S	13	2109:		in? (Specif	v Yes or No-	US	SA Race - Ameri	can Indian.
	Item	Ë	11. Marital Status  1 ☐ Never Married 2 ☑ Marri	Armed F	orces?		Was Decedent of H If Yes, specify Cuba	in, Mexican,	Puerto Rio	an, etc.)		Black, White,	
8	irs at	by	3 ☐ Widowed 4 ☐ Divorced	If Vac (i	ve Dates: 1942-	45	1 ☐ Yes 2 🙀 No	Specify:			Spe	ecity: Wh:	ite
5-0036	72 hours after death with the Maryland natural', or ttems 23s or 28s-1 show disal Examiner mutt be notified at	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occupa	ation	of working		16b. Kind o	of Business/In	
	E .	ple	(Specify only highes Elementary/Secondary (0-12)	College (		life.	DO NOT use retired	d)	or working				
2121	filed within I Hygiene. other then "	Completed	08	n/a	a .	Owne	er/Manage						Real Estate
9	m - 0 5	Be (	17. Father's Name (First, Middle, I	Last)				18. Mother	's Name (F	irst, Middle, i	Maiden Sun	name)	
<u>X</u>		٦ L		eroy	Elliot			-	izabe			Almo	
Maryland	2 sho and is my		19a. Informant's Name/Relationsh				ng Address (Street						
	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		Keith K. Price/	Son-in-La			5 Michae	lsford					
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	CA	ace of Dispo imetery, crei	osition (Name of matory or other plac	e)   2	Date 2/9/04		20c. Locati	on - City or To	own, State
E	Pages ment of tant; if it lury or o		*4 ☐Donation 5 ☐ Other (Sp	pecify)			alley Mem	. Grdi	ns.		Cimoni	Lum, Ma	aryland
Ball	permit. Pag Department Important: I any injury o		21 Signature Funeral Service I	ary la	ref	22	Lemmon Fi 10 W. Pa	uneral	Home	e of Du Timor	ılaney nium,	7 Valle MD 2	ey Inc. 1093
k			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death.	. Do not ent							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(a)	dut	01	1112	HILL	110	24			Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a consequ	ence of):		V V	100				
Е	Examiner		Sequentially list conditions	b. (U)	pula	Lie	mon	ller	MO	Ma	.,		
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	ence of):	1	. ().					
	and trans	Examiner	that initiated events resulting in death) Last	c. VQ	(or as a consequ	AA	Wha		W				
760,	ate be executed hysician and the burial-transit	E E		0000	(or es a consedo	erice orj.							
-	physi physi the l	dicai		d			1 0						
×	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	23c. If ves. ou	tcome of pregnar	ncy					234	Date of deliv	env
ВОХ	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal	death 3[	Ectopic pregnancy Other (specify)				200.	Month	Day Year
o.		iysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr	10Wf1								
<u> </u>	The law requires that the disterned by the sage 2 should be detached	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did to	tobacco use contribute to the cause of deat		
Records,	quires n sign									1 □ Y	es 2 N	o 3 🗆 Prot	bably 4 Unknown
Ö	w rec	lete								24a. Was a		4b. Were auto	opsy findings available
Ze E	The law cate has page 2:	Completed								autops	ned?	death?	empletion of cause of 2□ No
			25. Was case referred to medical					26 Place o	of Death (C	1 ☐ Yes :		1 🗆 185	20 100
of Vital		To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 E	ER/Outpatier	nt 3 DOA Oth	0.0		5 🏋 Reside		Other (Specia	fv)
ō	g Phys er this eral di		27. Manner of Death	28a. Date		28b. Time o				d. Describe ho			
<u>o</u>	Attending Is death.	atio	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	9	in, Day 16ar)	Injury		Yes 2 □ N	lo				
Division	ial or Attendir s after death. al Director: Af ed in by the fu	iffic	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and 289. Flat	e of Injury - At hor ling, etc. (Specify,	me, farm, sti	reet, factory, office		28f	Location (St City or Town		umber or Aura	al Route Number,
ō	tal or s afte at Dire ed in t	Certification:				,					, ,		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical		Examiner: On the I			h occurred at the tin vestigation, in my o						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0		4	29c. License	e number		2	9d. Date sig	gned (Month,	Day, Year)
)			DINCOL	M X	000	WM	M M	-24	-1()		Febr	uarv 9	9, 2004
1	12/		30. Name and address of person	who completed call	se of death (Item	23a) (Type,	Print)	,					
/			Susan Meltzer,	M.D. 122	21-3 Tu	ı11amo		Timon	ium,	MD 210	93		
	Sta Registr		31. Date filed (Month, Day, Year)	32.	Registrar's Signat	ure le	•						
	negisti	स्ता	□ 등등 H 그 V CUC↑	17.5	F 200 100	-							

			State of Maryland / Department of Health a  1- State State Certificate of Death	and Mental Hy	giene 2001	4 03679		
1	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of D Month FEBRO	Day Yeer	3. Time of Death		
	/Medic Examin	al .	Venus A. Friers  4a. Fecility Name (If not institution, give street and number)  5t. Papes Healthows Balton		4c. County of Dec			
1	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Days Hours  94 Yrs.	8. Date of B Min. (Month, D June 2	av. Year) C	rthplace (State or Foreign Country) Cginia		
	nyland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	the Ma	Director	Maryland Baltimore Catonsville  10e. Street and Number 10f. Zip Code	-	10g. Citizen of What C			
	3e or		1406 Ingleside Avenue 21228		U.S.A.			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Medical Exaticing must be notified at ODGE.	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No Specify:  3 ♣ Widowed 4 □ Divorced 1 □ Yes 2 ▼ No Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	Specify:			
Baltimore, Maryland 21215-0036	ithin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	t of working	16b. Kind of Business	s/Industry		
7	Hygien Hygien ther th		Unknown Housewife  17. Father's Name (First, Middle, Last)  18. Mother	n's Name (First, Middle	Own Home			
and	id be i ental i ked o	To Be		Unknown				
lary	2 shou and M Is man		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number					
e, ≥	1 and Health em 27 ther tr		Ronald Friers (Son) 1406 Incleside Aver  20a. Method of Disposition (Name of	nue Catons Date	oville, MD 20c. Location - City o			
mor	Pages ent of nt: If It ry or o		1 型 Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Lorraine Park Cemetery	2-10-2004	Woodlawn.	Marvland		
Baiti	permit. Departm Imports any inju		21. Signature of Funeral Service Lens e 22. Name and Address of Facility Witzke Funeral H 1630 Edmondson A	y Home of Cat Avenue Cat	tonsville, onsville, M	Inc. aryland 21228		
	Physician		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death  WEEK		
	/Medical Examiner		Due to (or as a consequence of):  HYPERTENSION			YEARS		
·,	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
8760,	physicials the burner	dlcal	d					
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	ysician/Me	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PENo 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of de Month	elivery Day Year	
	w requires that to be a signed by should be detail	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause			
Division of Vital Records,	The law re- ate has bee page 2 sho	Completed		24a. Wa auto peri 1 \( \text{Yes}	opsy prior to death?			
Vita	sician: certific rector,	Be	overmos?	of Death (Check only	one) sidence 6 Other (Sp	00(6)		
on of	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	1 Yes 2 No Hospital: 1 Inpatient 2 FVOutpatient 3 DOA Other: 4 Nut  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation  1 Injury 28b. Time of Injury 28b. Time of Injury 3 North 1 Yes 2 In	28d. Describe	how injury occurred	ec.iiy)		
Divis	al or Attsi s after dea il Director od in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours aff To the Funeral Discompletely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and a manner stated.	d place, and due to the th occurred at the time	e cause(s) and manner a , date and place, and du	as stated. e to the cause(s)		
)	To the within To the compl	Me	29b. Signature and title of certifier  Texdora Niculesa MD  29c. License number P1.76	05	29d. Date signed (Mon FEBRUARY	oth, Day, Year) 6, 2004		
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  7 EODORA NICULESKU, MD, STAGNES HE	EALTHCI	ARE, BAL	TIMORE, MO		
	Sta Regist		31. Date filed (Month), Pay, Yell) 2004 39 Registrar's Signature					

FRIERS VENUSA

SUZANNE  FOREMAN  AL Seating warms (if not maintained, pive storest and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number)  Supplication  Foreign and the store of continuous points and number			1 - For State Registrar	State of M		nd / Dep	artment of H rtificate of L	ealth and	Mental Hyg	_	04	036	80
FUNCTION    A Facility Name (if not institution, gives street and number)   4 Cory, Town, or Location of Death   4 Cory, Town, or Location   4 Cory, Town, or Locati	Physi	ician		, Last)							Year	3. Time of D	0
FUNCTION  POPULATION  POPULATI	/Med	dical				F0		Landing of Bar	1.69	1		10	М
S. Social Security Number  214 - 400 - 9516   1	Exam	niner	<		,				tn	4c. Coun	ity of Death	1/0	
The part of the	Funer	al			ge (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	1	9. Birthp	lace (State or	Foreign
The specific Cubes, weards, number of the specific Cubes, number of the spec	Directo			1□M 20F	62	Yrs.	Months Days	Hours Min	JANOnth. Por	1942	CRYE	(n)	
The specific Cubes, weeded, number of Cubes, nu	e Maryland a-f ehow	ctor		NA	1						1	0d. Inside City	
The specific Cubes, weards, number of the specific Cubes, number of the spec	3a or 28	I Dire	10e. Street and Number 2500 WEST BELVE	DERE AVE.						-	f What Coun	try?	
BENJAMIN  COHEN  MINYNON  KRAMER  19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Relation of Disposition  180. Relation of Disposition  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  180. Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  190. Moil Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  190. Moil Moil Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  190. Moil Moil Mailing Address ( <i>Street and Number or Rural Route Number. City or Town, State, Zip Code</i> )  190. Moil Moil Mailing Address (	death ms 2	nera	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Decedent of Hi	spanic Origin? (S		14. Ra			
BENJAMIN  CUHEN  MINYNON  KRAMER  19a. Informant's NameRelationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zp Code)  BRYAN FOREMAN/SON  1802 ROAN COURT  ELDERSBURG, MD. 21784  20a. Method of Disposition  1 \( List Big of the Pick Big of	ours after ral', or its	Š	3 ☐ Widowed 4 X Divorced	ed 1 Tyes 2 1	No				to Hican, etc.)				
BENJAMIN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  10b. Date of Expective Number of Programs or Rural Route Number. City or Town, State 2D Code)  10b. Date of Expective Number of Programs or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number of Rural Route Number. City or Town, State 2D Code On Number of Rural Route Number. City or Town, State 2D Code On Number of Rural Route	in 72 ho	oleted	15. Decedent (Specify only highes	t grade completed)		16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired,	ation furing most of wo	orking	16b. Kind of	Business/Ind	dustry	
BENJAMIN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  18b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  19b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code)  19b. Mailing Address (Street and Advance or Rural Route Number. City or Town, State 2to Code Code)  10b. Moiling Address (Street and Advance or Rural Route Number. City or Town, State 2to Code Code)  10b. Moiling Address (Street and Advance or Rural Route Number. City or Town, State 2to Code Code)  10b. Moiling Address (Street and Advance or Rural Route Number. City or	d with giene.	E	Elementary/Secondary (0-12)		5+)					REAL E	STATE		
BENJAMIN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 2D Code)  10b. Date of Expective Number of Programs or Rural Route Number. City or Town, State 2D Code)  10b. Date of Expective Number of Programs or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number. City or Town, State 2D Code On Number or Rural Route Number of Rural Route Number. City or Town, State 2D Code On Number of Rural Route Number. City or Town, State 2D Code On Number of Rural Route	at Hyg	0	17. Father's Name (First, Middle, I	Last)				18. Mother's Na	me (First, Middle, M	fa <i>iden Sum</i> a	ıme)		
BRYAN FOREMAN/SON  1802 ROAN COURT ELDERSBURG, MD. 21784  20a. Method of Disposition (Name of commonly commonly or other (speechy)  20a. Method of Disposition (Name of commonly commonly or other (speechy)  20b. Place of Disposition (Name of commonly commonly or other (speechy)  21. Signature of Figure 3 Service Licensee  22. Rame and Address of Facility SOL LEVINSON & BROS. INC.  8900 REISTERSTOWN - PIKESVILLE, MD 21208  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or conditions resulting in death)  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or conditions resulting in death) Last  23c. If yes, outcome of pregnancy arrest (speechy)  23c. If yes, outcome of pregnancy arrest (speechy)  23c. If yes, outcome of pregnancy arrest (speechy)  23d. Date of delivery Month Day  24a. Whs an autopsy profit of the cause of completion of cause of the cause of completion of cause of the cause of cause o	Menta Menta Brrked		BENJAMIN		COHE	N		MINYNO	N		KRAM	IER	
8900 REISTERSTOWN - PIKESVILLE, MD 21208  23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediated Cause (Final diseases or condition resulting in death)  Medical Examiner  10	d 2 sh th and th and 7 le m treum											Code)	
8900 REISTERSTOWN - PIKESVILLE, MD 21208  23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death)  Medical Examiner  Proposition  Medical Examiner  Sequentially list conditions, if any, leading to immediate cause (Final disease) or sorting in death)  Due to (or as a consequence of):  Due to (or as a	Heet Heet tem 2			3011	20b. F	Place of Dispo	osition (Name of		The same of the sa			wn, State	
8900 REISTERSTOWN - PIKESVILLE, MD 21208  23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death)  Medical Examiner  Proposition  Medical Examiner  Sequentially list conditions, if any, leading to immediate cause (Final disease) or sorting in death)  Due to (or as a consequence of):  Due to (or as a	Pages nent of unt: If I					-			2004 W	(OODLA)	WN. MD	).	
23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immedical Examiner  Particular Medical Examiner  Sequentially list conditions on the condition resulting in death)  Sequentially list conditions on the condition resulting in death)  Sequentially list conditions on the condition resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a conse	permit. Depentr Imports ony inju	ouce	21. Signature of Funeral Service I	icensee	/	22	2. Name and Addres	s of Facility SO	L LEVINSO	N & BI	ROS. I	NC.	
Immediate Cause (Final disease)    Comparison   Cause (Final disease)			23a. Part1. Enter the disease, or	complications that cause	d the deat						טוי בוב	Approximate	
Due to (or as a consequence of):    Second   Column   Col	/Medica Examine	al er	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissaes or mun, that initiated events	Due to (or as	a conseq	uenca of):	اه د معد ماه	мА				Onset and De	ath
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  1 Yes 2 No  27. Manuar of Death  28. Date of lines.	certificate be exending physician ause as the burial-ial-	cai	d								ate of delive	rv.	
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  1 Yes 2 No  27. Manuar of Death  28. Date of lines.	the death by the atte	hysicia	in the past 12 months? 1 Yes 2 No										
24.4 Vas all autopsy performed?  1	quires than signed I	þ											
25. Was case referred to medical examiner?  1   Yes   2   No   Nursing Home   5   Residence   6   Other (Specify)	aw re	piet		1		0					Were autop	sy findings av	ailable
26. Place of Death (Check only one)  27. Manner of Death 1 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 3 DOA 28. Injury at Work? 3 Sac Sac Service of Death (Check only one)  28. Date of Injury 3 DOA 3 Sac Sac Service 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury at Work? 4 Homicide  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury at Work? 4 Homicide  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury at Work? 4 Homicide  28. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury at Work? 4 Homicide  28. Date of Injury at Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury at Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury at Nursing Home 5 Residence 6 Other (Specify)  29. Section 1 1 Secti	n: The licate har, page	O						perform 1 Yes 2	autopsy prior to comple performed? death?			Se or	
27. Manner of Death   28. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   28d. Describ	sicia s certi firecto	0 0	examiner?	Hospital:	ant 2	EB/Outpot	othe				has (C)		
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)  29a. Certifier (Check only one)  29a. Certifier 29b. Signature and title of certifier  29c. License number 29d. Date signed (Month Day Year)	ding Phy h. After this funeral c	H-	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	iry	28b. Time of	f 28c. Injury Work	at ?				)	
29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month. Day, Year)	or Atten after deal Director	ertifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of Inj	ury - At ho c. <i>(Specif</i> )	ome, farm, str y)			28f. Location (Stre City or Town,	eet and Num State)	ber or Rural	Route Numbe	)r,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Year)	e Hospite 124 hours Funeral letely fillec		(Check only 2 Medicel E	:xaminer: On the basis o	i examina	wledge, death tion and/or in	h occurred at the time vestigation, in my op	e, date and place inion, death occu	e, and due to the cau arred at the time, dat	use(s) and m te and place,	anner as sta , and due to	ated. the cause(s)	
F \$ F 8	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number	29	d. Date signe	ed (Month, D	Day, Year)	
RES - 060 FEBRUARS 6, 2004	,	,		Ja.				5-060	s fr	BRUM	6, 6	2004	
30. Name and address of pirson while completed cause of death (Item 23a) (Type, Print)	ų.							4. 4					
State State  State  31. Date filed (Month, Day, Year)  Registrar  1.4 Yolfo M.D. 1401 WEST BEWEINTE AVE, Pharme MO 2171( 32. Registrar's Schalure		- 4		32. Registr	ar's Sina	iture	Villiance	MU	-111	- <u>-</u>			

DHMH 17 Rev 1/2001

SULATUS

ORIGINAL

		•	For State Registrer		Department of Health and I	Mental Hygier	Ca U U 17	03681
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	_	Samuel G	reen		February	02 2004	8:43AM
-	Examin		4a. Fecility Name (If not institution, give stre	. ()	4b. City, Town, or Location of Death	1	4c. County of Death	
			Maryland GENE  5. Social Security Number 6. Sex	Ral (+05P1+a) 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs.	B. Date of Birth	9. Birthpla	ace (State or Foreign
1	Funeral Director			005 17/3	rrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Yea	124 Ge	
	Pu ,		Usual Residence of Decedent  10a State 10b County	10c. City, Town	1 Or Location	J /	10	d. Inside City Limits
	ehow	2	10a. State 10b. County	R.	1 to con co			1 ∑Yes 2 □ No
	28a-1	ect	10e, Street and Number	pa	10f, Zip Code	10g. (	Citizen of What Count	ry?
	3a or	i Di	5246 N. Fut	aw Place	21217		1151	4
	death ms 2	Funeral Director	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
9	or ite	Fu	1 Never Married 2 ☐ Married	1 Yes 2 □ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	3 113211 3131	Specify: 7)	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23s or 28s-f show ont, tra Medical Exact are must be rediffed at	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Year or Dates:	Decedent's Usual Occupation	16h	Kind of Business/Ind	ustry
7.	in 72 n "na fedic	Completed	(Specify only highest grade of		(Give kind of work done during most of wor life. DO NOT use retired)	rking		/
212	giene.	E O	Elementary/Secondary (0-12)	H E	ducator	Mo	organ Sta	te Universit
	be file ital Hyg id othe event,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maid	en Sumame)	
yla	Ment Ment arked	To	Joseph Gre	en	tano	Niyer	5	0.41
Maryland	12 sh h and 7 le m traum		19a. Informant's Name/Relationship (Type,	Print) (Friend) 196.	Mailing Address (Street and Number or Ru	iral Houte Number, Cit	or rown, State, Zip	51045
	1 and Health em 27		20a. Method of Disposition	20b. Place of	Disposition (Name of	Date 20c.	Location - City or Tov	wn, State
Baltimore,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortant: If item 27 le marked other then "natural", or items 23s or 28s-f ehow injury or other traumatic event, the Medical Exertinet must be notified at injury or other traumatic event, the Medical Exertinet must be notified at 8.		1 ☐ Burial 2 X Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	cometer Green	y, crematory or other place)	12004 P	alto M	d
altir	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service Licensee	1.0	22. Name and Address of Facility	- /-	-( 11 - 0	
ñ	Depa Impo eny i		Corenha	Kuss	2222 WiNorth	Ave. B	alto. Md.	21216
			23a. Part I. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do r	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	/	hythymia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):			
1		35	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	arciomy oblithy			
	nted	Examiner	Cause (Disease or injury	Huneste NSin				
ć	b be executed sician and s burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):			
120	2 > 2	icai	d	reripheral 1	lascular Discuse			
<b>68</b>	The law requires that the death certifica tite has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:					
Вох	ath co	ian/	in the past 12 months?	. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	ry Day Year
o.	the de	iysic	1 Yes 2 No	9 Unknown	5 Galei (specify)			
<u>α</u>	s that in ned by deta	by Ph	Part II. Other significant conditions contri	buting to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobaco	o use contribute to the	e cause of death?
rds	w requires been signi should be	ed b				1 🗆 Yes	2 No 3 Proba	ably 4 Dunknown
900	ne law requ has been ge 2 shouli	piet				24a. Was an autopsy	24b. Were autop	sy findings available appletion of cause of
Ä		Completed				performed 1 Yes 202	death?	2 T No
of Vital Records,	Physician: The this certificate and director, pag	Be	25. Was case referred to medical examiner?	spital:	Other	ath (Check only one)		
of	Phys	7	1 ✓ Yes 2 ☐ No	28a. Date of Injury 28b. 1	TIPATION 3 DOA 4 NUTSING P	dome 5 Residence 28d. Describe how in		)
on	Attending For death.  ector: After by the funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of njury at Work?  M 1 Yes 2 No			
Division	or Attendiater death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural	Route Number,
Ö	tal or rs afte al Dir ed in	Certification:	T I I I I I I I I I I I I I I I I I I I	Dandary, etc. (opechy)				
/	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ien: To the best of my knowledger: On the basis of examination an and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifie	and marines stated.	29c. License number	29d.	Date signed (Month, L	Day, Year)
	F ≯ F ŏ		10010	Mount	MD 89478	Fo	hrungy:	2.004
•	175		30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Print)	110	or wary o	0,~0.7
	2)		Sovia Yousuf M	I.D. GO Max	MD SY478 (Type, Print) RYLAND GENERAL HO	spital		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		•		
	Regist		FEB 1 0 2004	A. J. A. A. A.				
UF	HMH 17 Rev 1/2	:001	d <sup>2</sup>	A Secretary St.	IGINAL			

			For State Registrar	State of Maryla		rtment of F		Mental Hy	giene 2	2004	03682
	Physici		1. Decedent's Name (First, Middle, Last,	_	ess			2. Date of D Month	eath Day	Year	3. Time of Death 4:58PM
	/Medic Examin	er	4a. Facility Name (If not institution, give FRANKIIN Squase 5. Social Security Number 6. Sec	HOSPHAL Ce	enter s. last birthday)	Raca	r Location of Death		4c. Co	<del>/- /</del>	10 FC Diace (State or Foreign
	Director		Usual Residence of Decedent	90	Yrs.				,1913		yland
	death with the Maryland ma 23a or 28a-f ehow mat be codiffed at	5	10a. State 10b. County  MD Ba 1	timore 10c. 0	City, Town or Loc						10d. Inside City Limits
	the M	recto	10e, Street and Number	CIMOLE	-	Baltimo	re		10a Citizen	of What Cou	1 Tyes 2 The
	th with 23e or	al Di	8107 Candle La	ne		2122	1		USA	or writer cour	шуг
920	or Ite	by Funeral Director	11. Marital Status  1 Never Married Amarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	0- 14.	Race - Americ Black, White, ecif <b>Whit</b>	etc.
5-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grade		(Give k	ent's Usual Occup	during most of wor.	king	16b. Kind o	of Business/In	dustry
2121	s i and 2 should be filed within f Health and Mental Hyglene. item 27 ie marked other than ' other traumatic event, Ins Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	er Mech	anic		Exx		
Maryland	Aental H rked ott tic even	To Be	17. Father's Name (First, Middle, Last)  John Gress				18. Mother's Nam	ne (First, Middle e Hoff		name)	
Aary	2 should be and Mental ie marked or raumatic ev		19a. Informant's Name/Relationship (Ty	·	1		and Number or Ru	ral Route Numb	er, City or To		Code)
No.	s 1 and 27 item 27 other tr	10	Ruth M. Gress 20a. Method of Disposition		810°	7 Candl ition (Name of atory or other place	e Lane	Baltim Date		D on - City or To	own State
OE E	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			atory`or other plac ofFaith		12/04		ville	
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service License	annelle	1	Name and Address	ss of Facility Co Mace A	nnelly ve. Ba	Funer Itimo	alHom	eofEssex
68760,	Physician buy sician and physician and physician and physician and physician and sician stress in the private in the private in the physician stress i	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failures. List phly or Immediate Cause (Final disease or condition resulting in death)  Cequentially list curditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	r the mode of dyin	g, such as cardiac		rrest,		Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal déath 3 □6	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
	quires that n signed t	d by PI	Part II. Other significant conditions con	tributing to death but not re	sulting in the und	derlying cause give	en in Part I.	23e. Did t	/		e cause of death?
al Records,	ician: The law requir certificate has been si rector, page 2 should	Completed by	CAP					24a. Was auto perfo		b. Were autoprior to condeath?	osy findings available npletion of cause of 2 No
of Vital	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 npatient 2	☐ ER/Outpatient	3□ DOA Othe	26. Place of Deat				
on of	iding Phys th. : After this funeral du	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4   Nursing Ho	28d. Describe			')
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stree	et, factory, office		28f. Location (: City or Tox	Street and Nu wn, State)	mber or Rura	Route Number,
	• Hospi 24 hour • Funer etely fills	Medical	29a. Certifier (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the timestigation, in my op	ie, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as st	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. License				ned (Month, I	Day, Year)
			) gran	2		D57	1255		2/9/	2004	
	10		30. Name and address of person who co $D\Gamma$ $ames$ $\Gamma$	npleted cause of death (Ite	m 23a) II pe, P	rint)	Queux D	rive b	allian	te n	10 21937
	Sta Registr	_	31. Date filed (Month, Day, Wear)	32. Regist ar' Sign	ature	1.0	The state of	100	4111111	1 -	1001

		4			partment of Health ar		- 4004	03683
			State Registrar AMEND ITEM #1 PER PHY  Decedent's Name (First, Middle, Last) WII	G828 2/10/04 91	E, Jr.	2. Date of Deat	eg. No. th Day Year	3. Time of Death
п	Physicia /Medic		William Occ	orgo d	IA A II C	02	04 200	1 D'AM
1	Examin		a. Fecility Name (If not institution, give street and nur	nberX	40. Gity Town, or Location of	Death	4c. County of Death	1
			Social Security Number 6. Sex	7. Age (In yrs. last birthda	v) If Under 1 Year   If Under 24			plece (State or Foreign
Ş.	Funeral Director	4	18-60-2510 10M 2DF	51 Yrs.	Months Days Hours	Min. Month, Day	3°1952 Ma	ryland
	D		Jsual Residence of Decedent  10a, State 10b, County	10c. City, Town or	Location			10d. Inside City Limits
	show	5	MD Baltimore	Pikesvi	. 1			1 ☐ Yes 2 PNo
	28a-f	rect	10e, Street and Number		10f. Zip Code	1	log. Citizen of What Co	untry?
	death with the Marylend rms 23e or 28e-f show	Funeral Director	4'+06 Bonnie Brae	Rol.	21208		USA	
	ems (	Iner	11. Marital Status 12. Was Dec	edent Ever in U.S. 13 prces?	<ol> <li>Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican.</li> </ol>	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fi	1 Never Married 2 Married 1 Yes If Yes, Gir 3 Widowed 4 Divorced Year or D	9	1 ☐ Yes 2 ☐ No Specify:		Specify: B	ack
21215-0036	within 72 hours after ene. than "natural", or the ne Medical Exercities	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occupation ve kind of work done during most of	of working	16b. Kind of Business/I	ndustry
218	ithin 7 ne. "n Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (	1-40r 5+)	. DO NOT use retired)		City	
	filed with Hygiane other tha		77. Father's Name (First, Middle, Last)	14/0	echanic 18. Mother	s Name (First, Middle,	Maiden Sumame)	
anc	d be fi	To Be	William George SR		Erne	estine E	llison	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylen to f Health and Mental Hygiens.  If filem 27 is marked other than "natural; or thems 23a or 28a-f show if them 27 is marked other than "natural; or there in ust be notified at or other traumatic event, the Modical Examiting must be notified at	-	19a. Informant's Name/Relationship ype, Print)	19b. Ma	ailing Address (Street and Number	or Rural Route Number	r, City or Town, State, Z	
	and 2 ealth in 27 i		William George SR	. Father 4	tob Bonnie l	brue Kd.	PIKESUITE I	ND 21208
Baltimore,	Pages 1 nent of H nnt: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	State cemetery, c	rematory or other place)	-12-04	Almoni'lla	MAN.
Ħ	그 문원 중 .		* 4 □ Donation 8 □ Other (Specify)  21. Signature of Funeral Service (cenum)	Metro (	22. Name and An ress of Facility	75. 0 )	utorisvine,	21229
Ba	permi Depa Impo sny in		Soull Wart		Sary P. March F	1 4 2 70 FRE	dhilton Pas	21229 s Balto, mo
4			23a. Part . For the disease, or compations that shock, heart failure. List only one laps on the company of the shock of th	aused the death. Do not sach line.	enter the mode of dying, such as co	ardiac or respiratory arr	rest,	Approximate Interval Between Oaces and Death
	Pnysician	85	Immediate Cause (Final disease of condition resulting in death)	200100	ony tack	one		TOAS
	/Medical Examiner		Due to	(or as   consequence of):	mal to	0120004	114	FORY
	E MATERIA	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of):	CCD 1	CHOR	JIII	1
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.					
60,	be exectan a		resulting in death) Last Due to	(or as a consequence of):				
68760,	death certificate be executed e attending physician and od for use as the burial-transit	edical	d					
Box (	leath certificat attending phy I for use as th	Physician/Med		itcome of pregnancy birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of del	
	death	sicia	in the past 12 months?	nant at time of death	5 Other (specify)		Month	Day Year
P.0	that the dended by the a		9 Unknow		e underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds,	es Ded	d by	Arute KenA	Fail	2000	1 □ Y	res gNo 3□Pr	obably 4 Unknown
Record	s been s should	Completed	Human Immunos	eliciona	Virus inte	Cta V4a. Was	an 24b. Were au	topsy findings available completion of cause of
Re	The law ate has page 2	mo	7.0.1.1.0.5			autop perfor 1 Yes	rmed2 death?	2 □ No
Vital	sician: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?		Othon	of Death (Check only or		
of	this al di	To.	1 Yes 1 No Hospital: 28a. Date	Inpatient 2 ER/Outpa of Injury 28b. Time	The second secon	-	lence 6 Other (Spenow injury occurred	cify)
	fter Ine	tion	1 Natural 5 Pending (Mor	nth, Day Year) Injui				
Division	r Atter er dea rector by the	Certification:	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, ling, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
۵	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		~			I mlana and div. 4: 4:	201102/2\ 2==	ctated
	24 hos 24 ho Fune etely f	Medical	(Check only 2 Medical Examiner: On the	e best of my knowledge, d basis of examination and/o nner stated.	eath occurred at the time, date and r investigation, in my opinion, death	h occurred at the time, o	date and place, and due	to the cause(s)
	To the Wilnin To the	Me	29b. Signature and title of certifier		29c. License number	10	29d. Date signed (Mont	h. Day, Year)
	0		H.IVal &	ende	J D271	63	2/4/	2004
	( )		30. Name and a dre of person who cor pluted cau	and death (Item 23a) (Ty	pe, Print)	بہ اسلہ	Fal	
	St	ate	31. Date filed (Month, Day, Year)	Registrar's Signature		MILLERIT	(37)	(hai
	O.	rar	1 0 2004	M. M.	sach 2			

CPM 04-01028

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. DENISE GASKINS State of Maryland / Department of Health and Mental Hygiene Unpend Item#23a,27,28a-f,Per ME,G828;2/447/Quesof Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** DENISE 2004 February 05, 19:16 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland General Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 218.76.0620 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at MD 1 Yes 2 No BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number With 1901 death ! Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0036 natural, or If Yes, Give Year or Dates: Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's/Name (First, Middle, Maiden Sumame Be nt of Health and Mental H
t: If item 27 Is marked ott
y or other treumatic even ပ္ Pages 1 and 2 should mant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20b. Place of Disposition (Name of 2.11.04 BORTIMORE MARYLAND 1 Burial 2 Cremation permit. Page Department of Important: If any injury or REEN MOUNT CRYMATORY ⁴ 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility CREMATION SOLVICES VA. 21. Signature of Funeral Service Licensee BACT, MORE NITTIONITE PIKE BACTO, NO 2122 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Physician Cocaine Intoxication /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 4 Unknown 1 🗌 Yes 2 No 3 Probably Be Completed Were autopsy findings available prior to completion of cause of death?

See 2 No 24a. Was an certificate has autopsy performed? Yes Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2.EP/Outpatient 3□ DOA 1√ Yes 2 No 1 🗌 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 🗀 Pending 6:36 2/5/04 1 ☐ Yes 2 No unknown death. investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide found: private dwelling Baltimore City, Movemue, Apt.1, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. February 06, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

2004

EFR1

ocks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2 6 2004 11:40a Edward Gentry Wesley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Multi Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 € M 2 □ F N.C Director 238-20-3102 86 5-12-17 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director Md. NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21202 Funeral 501 E. Preston St. Apt. 116 USA 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Itame ; 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1♥ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Varies 7th grade it of Health and Mental Hygie If Item 27 le marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Gentry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Wellborn Sister 501 E. Preston St. Apt. 116, Baltimore, Md. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **X**Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Depertment of Important: If any injury or once. 2-11-04 Md. Vet. Cem. Crownsville, Md. 22. Name and Address of Facility 21. Signature Funeral Service License Baltimore, Md. 21202 1101 E. North Ave March F.H. East 23a. Part 1. Enter the disease, or copolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death BRTERIOSCIEROTI Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be execut Due to (or as a consequence of) Box 68760, physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months?

1 Yes 2 DNo...

9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 1 Yes 2√Z No 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 his Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by within 24 hours after To the Funeral Direct 4 Homicide Hospital TILL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier death (Item 23a) (Tx e, Fint) 30. Name and address of erson who completed gause HOWARD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

**ORIGINAL** 

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ffin Please Type or Print	in Black Ind yland / Depai					ble.	
1 - State Orivial State orivial Registrar Unpend Item#23a-27,Per ME.					Reg. No.		UJoBb
1. Decedent's Name (First, Middle, Last)  JOHNNIE Ellistt C	TI ASI			2. Date of De. Month	Day  Uary 2,	Year 2004	3. Time of Death
4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or I			4c. County	of Death	V•22. F
Sinai Hospital  5. Social Security Number 6. Sex 7. Age (	In yrs. last birthday)	Baltim If Under 1 Year	If Under 24	Hrs. 8. Date of Birt	h	9. Birthpl	ace (State or Foreign
2/3 52 2835 DEM 20F 5	Yrs.	Months Days	Hours	Min. (Month, Da		Hory	Javo
Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Loc	ation				10	Od. Inside City Limits
Mary low M/m	3 plts	10f. Zip Code			10g. Citizen of V	What Count	Payes 2 No
100. Street and Number 5506 Magnetia Arr		212	15		US		.,,.
11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. W	/as Decedent of His Yes, specify Cuban	panic Origin , Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Rac Blac	e - America k, White, e	
3 Widowed 4 Divorced  1 Yes, 22 No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify	Blo	ck
15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa and of work done di O NOT use retired)	tion uring most o	working	16b. Kind of Bu	usiness/Ind	ustry
Elementary/Secondary (0-12) College (1-4or 5+)		HOREMAN			Private		ky
17. Father's Name (First, Middle, Last)  Frank Griffin				Name (First, Middle,			
19a. Informant's Name/Relationship (Type, Print)		Address (Street a	nd Number o	or Rural Route Numbe	er, City or Town,	State, Zip	
Jim My Grithin BruTHEN  20a. Method of Disposition				Date Date	20c. Location -	City or To	wn, State
Donation 5 ☐ Other (Spegfly)	cometery, crem	atory or other place	" 0	10/04 211A MAI			
21. Signature of Funeral Service Vicensee	22. 52	Name and Address	of Facility	ENATHAN WWW LUAD 71215	1- HULK	u A	und hon a
23a. Part / Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ente				rrest,		Approximate Interval Between
resulting in death)	sive Atherose	clerotic Ca	rdiovas	cular Diseas	е		Onset and Death
	consequence of):						
	consequence of).						
that initiated events c.	consequence of):					T	
d			<del></del>				
IF FEMALE: 23b. Was decedent pregnant					23d. Da	te of delive	ry
in the past 12 months?  1 Yes 2 No  1 Ves 2 No		Ectopic pregnancy Other (specify)			Mo	nth	Day Year
Part II. Other significent conditions contributing to death but	not resulting in the un	derlying cause give	n in Part I.	23e. Did t	obacco use cont	ribute to th	e cause of death?
				10	Yes 2 □ No	3 Proba	ably 4 Unknown
				24a. Was	osy	Were autor prior to con death?	osy findings available inpletion of cause of
25. Was case referred to medical			OF Place o	1 ☐ Yes	2 No	1 Yes	2 No
examiner?  1 X Yes 2 No Hospital: 1 X Inpatient	2 ER/Outpatient	3□ DOA Othe		ing Home 5 Resi		er (Specify	)
27. Manner of Death  1 Shatural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day 1) 28b. Place of Injury (Month, Day 1) 2b. Place of Injury	Year) 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? ′es 2 ⊡ No		how injury occur	red	
3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	Route Number,
29a. Certifier (Check only one)  1 Certifying Physician: To the best of examiner: On the basis of earn manner state	xamination and/or inv	occurred at the tim estigation, in my op	e, date and inion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as standard	ated. the cause(s)
29b. Signature and title of certifier		29c. License	number		29d. Date signe	d (Month, L	Day, Year)
Theolin M. Kida	(s)	O.C.	1.E.		Febru	ary 5	, 2004
30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, F		n Str	eet, Balti	more M	arula	nd 21201
31. Date filed (Month, Day, Year) 32. Registrar	's Signature		VLL	coty Dure	LINCE C, I'I	тТТО	THE CICUI

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

FEB 1 0 2004

				For State Registrar	tate of Ma	aryland / Dep <i>Ce</i>	artment of F			iene <sub>2</sub> 0		03687
		Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
		Physici /Medic		Andrew Robert					Februar	4 6, 2	004	8:30 A M
	4	Examin		4a. Fecility Name (If not institution, give stre				Location of Death	h	4c. County		
				Upper Chesapeake M 5. Social Security Number 6. Sex		CENTER e (In yrs. last birthday,	Bel A	UT If Under 24 Hrs.	8. Date of Birth		r ford	ace (State or Foreign
		Funeral Director			2□F /. A9	89 Yrs.	Months Days	Hours Min.	Jan. 3,	1915	Count	ryland
		_		Usual Residence of Decedent								
		show	_	10a. State 10b. County		10c. City, Town or L					10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
		Ba-f	Director	Maryland Harford		Edg	ewood			0.000	4/5-1-0-1-1	
		with the Maryland is or 28s-1 show Let rediffed at		10e. Street and Number			10f. Zip Code 210	40		og. Citizen of \	what Count	sy:
		seath	Funeral	1205 Hanson Road  11. Marital Status	Was Decedent 8	Ever in U.S. 13.	Was Decedent of H				e - America	
0	9	after or Iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 N If Yes, Give	lo	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		to Rican, etc.)		k, White, e	ite
36	93	72 hours after death with the Maryla "natural", or Items 23a or 28a-1 shov afted Exar traces be modified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:					Specify		
83	215-0036	within 72 hours after ene. than "natural", or Ite	lete	15. Decedent's Educat (Specify only highest grade of	on ompleted)	16a. Dece (Give	dent's Usual Occup kind of work done of DD NDT use retired	ation during most of wor	rking	16b. Kind of Bi	usin ess/Ind	ustry
0	212	withir ene. than	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5	+}	tractor	"		Constru	uctio.	n
4		ermit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, I as Mance.	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	-		
04	Maryland	should be ind Mental marked o	To B	Andrew Goss				Regina	Muel	ler		
9	lan	2 sho and Is ma		19a. Informant's Name/Relationship (Type,			•		ural Route Number,			Code)
2		1 and 3 Health tem 27 other tra		Mrs. Mary L. Bocks	tie (sis	20b. Place of Dispo		., Chesa	peake Cit	y, MD		wn State
.0	õ	ages to to Hite		20a. Method of Disposition  1	oval from State	cemetery, cre	matory`or other plac	· 1			•	
	Baltimore,	iit. Pag artment ortant: I injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licensee</li></ul>		St. Josep	ON CN. Cen 2. Name and Addre	n.   Z/IU	)/2004 Li himunek F	rucea	Lon, N	iarykana
	Ba	permit. Departm Importa any inju		1-Than			9705 Beld	air Rd.,	Baltimor	unerax e, MD :	110me	5
				23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	ions that caused ause on each lin	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition		cute K	espira	Jory	Laisu	re		Onset and Death
	1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	,	1				
			e	Sequentially list conditions, if any, leading to immediate	Due to (or as	a of insequence of):	nel		,			days
	ON	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (processor or nury that initiated events c	U	manns	is. 11	Manu	traci	Trube	chim	days
38	ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):	7- /	117				11.0
910	8760	6 × 6	dicai	d	^	liabete	, Mel	liles				glais
O	Box 6	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23c.	If yes, outcome		_			23d. Dat	e of deliver	V
F	B	death e atten	Iciar	in the past 12 months?	1☐Live birth 4☐Pregnant at		⊒Ectopic pregnancy □ Other <i>(specify)</i>	·		Мо		Day Year
	P.0	<b>9</b> ≠ ₹	hys	9 🗆 Unknown	9□ Unknown							
+-		Se C 00	þ	Part II. Other significant conditions contril	outing to death bu	at not resulting in the u	ınderlying cause giv	en in Part I.		acco use cont s 2 ☐ No	ribute to the 3 ☐ Proba	a cause of death? ably 4 Munknown
Andrew Robert	ecords,	≥ 0 ts	Completed						24a. Was an		Were autop	sy findings available
80	Re	The lay	dmc						autopsy perform	egl?	prior to com death?	npletion of cause of 2□ No
3		an: T	a)	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ath (Check only one		163 2	20.100
શું	of Vital	Phyeician: this certific ral director,	To B	T Tes 21 NO	oital: 1 Inpatie		nt 3 DOA Oth	er: 4 🗆 Nursing H	lome 5 Resider	nce 6 □Oth	er (Specify)	)
po		iing Phyeician: The lav n. After this certificate has funeral director, page 2		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o	Wor		28d. Describe how	w injury occurr	ed	
V	Sio		cati	2 Accident investigation	no. Olean of Iniv	ury - At home, farm, st		Yes 2 □No	28f. Location (Str	aat and Numb	or or Rural	Route Number
5	Division	al or A safter I Direc d in by	Certification:	4 Homicide determined	building, etc		reet, factory, office		City or Town,	State)	ei oi ribiai	riodio riambor,
6055		To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (	29a. Certifier 12 Certifying Physici (Check only one) 12 Medicel Exeminer								
		To the vithin 2 To the comple	Me	29b. Signature and title of certifier	0		29c. Licens	e number	29	d. Date signed	(Month, D	iay, Year)
				· alle d	Dry	y UDD	$\perp D$	-181	119 1	ebru	ery 6	2,2004
		Y		30. Name and address of person who comp	leted cause of de	eath (Item 23a) (Type,	Print) arfor	d Road	Swife 1	05 F.	1/ch	MI
		Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	10 41		2 1/2 /	_ / 0	2	1047
		Registr		FCD 1 0 2004	Be en	a B	South					- /

			For 1 _ State	State of Maryla				lental Hyg	iene	. 03688
			Registrar		Cer	tificate of L	Jeam	2. Date of Deat	eg. No.	3. Time of Death
	Physici /Medic		1. Decedent's Name (First, Middle, Last	)		Gar	nett	Februa Februa	Day Year	5:55AM
4	Examin		4a. Fecility Name (If not institution, give	street and number)	1	4b. Cily, Town, or	Location of Death	0.1.	4c. County of Dea	th
1			The Johns	Hopkins	Hospital	Bal	timore	City		
	Funeral Director		5. Sociel Security Number 6. Se 144 30 7545	x 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG • 2	2 1940 N	thplace (State or Foreign ORTH AROLINA
	<b>P</b>		Usual Residence of Decedent							
	ahow	_	10a. State 10b. County	10c.	City, Town or Lo					10d. tnside City Limits 1√ Yes 2 No
	8a-1 s	50	MD. N/A		BALTI					Λ
	ith th		10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry ?
	s 23s	Ta l		N STREET  12. Was Decedent Ever in	11.5	212		positu Van es No	U.S.A.	accen Indian
	item item	n n	11. Marital Status  1 Never Married  Married	Armed Forces? 1 ☐ Yes 2X No	10.3.	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Btack, Whi	
36	I', or	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐XNo	Specify:		Specify:BL	ACK
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at		15. Decedent's Edu		16a. Deced	ent's Usual Occupa	ation		16b. Kind of Business	/Industry
215	7 nin 7.	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired	<i>luring</i> most of work )	ang		
21	d with	Completed	9th		ICCU	J NURSE			NURSING	
	be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	Maiden Surname)	
ylai	ould by Ment	일	GEORGE HENR	Y JOHNSON			CORA WA	ARREM		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-1 show amply injury or other traumatic event, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship (T) KAY STALLINGS (	•					City or Town, State, MD. 212	
	s 1 an f Heal ftem 2 other		20a. Method of Disposition	200	. Place of Dispos			7	20c. Location - City or	
Baltimore	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 4 ☐ Departion 5 ☐ Other (Specify)		•		. !	3 2004	BALTO, MI	4
alti	Depermit. I Depertm Importar eny inju		21. Signature of Funeral Service Licens	14	22	Name and Address	s of Facility	STOREST STORES		10.7
ä	permi Deper Impo		Demadere	6. Serves	6 12	IALVIN E	RESTON	GS FUNI	ERAL HOME	 21212
	* *		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de	eath. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	LTO, MD.	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a Anoxic	Locin	40.40.0				Onset and Death
47	/Medical		resulting in death)	Due to (or as a cons	brain sequence of):	damao	)~			3 oays
	Examiner		Sequentially list conditions	b Asystoli	c card	iac arr	est			5 days
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons						3
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Seizure						5 days
760,	ate be executed hysician and the burial-transit		rosuling in doutry cast	Due to (or as a cons	sequence on:					
687	physi the t	dical	•	d						
9 X	leath certificat attending phy I for use as th	/Me	IF FEMALE:	23c. If ves, outcome of pre-	gnancy				23d. Date of de	livery
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 [	Ectopic pregnancy Other (specify)			Month	Day Year
P.0.	ires that the death signed by the atte d be detached for	ysi	1 □ Yes 2 No 9 □ Unknown	9□ Unknown						
	that ned b	Y P	Part II. Other significant conditions co	ntributing to death but not i	resulting in the ur	iderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	quires n sigr	q p	Alcahol abuse					1 □ Ye	s 25 No 3□P	robably 4 Dunknown
Ö	w requir s been si should	jete						24a. Was ar		utopsy findings available
Re	sicien: The law requires that the death certifical certificate has been signed by the attending phirector, page 2 should be detached for use as the	Completed by Physician/Med						autops: perform		completion of cause of
Vital		a	25. Was case referred to medical				26. Place of Deat	th (Check only one		
\ <u>&gt;</u>	> 00 0	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Reside	nce 6 Other (Spe	cify)
0	Attending Physicien: r death. sctor: After this certifici by the funeral director.		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho	w injury occurred	
, <u>i</u> ë	endir oath. or: Af he fur	atic	2 ☐ Accident investigation				Yes 2 □ No			
Division of	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		et, factory, office		28f. Location (Str. City or Town	reet and Number or R r, State)	ural Route Number,
	oital o			1				<u> </u>		
	To the Hospital or Attending Ph within 24 hours after death To the Ethneral Director: After the completely filled in by the funeral	edical		rsician: To the best of my liner: On the basis of exam and manner stated.						
	ro th within ro th	Me	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Moni	h, Day, Year)
			DAD-	2 MD		RES	-000	Fe	ebruary 8	, 2004
	68		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type,	Print)	. ^	11:		
			John Doolen	600 N			eet 13	altimore	, Maryland	21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	acked				
1	Registr	ar	EER 1 0 2004	frate man	no pholps	Ex. Calendala.				

State of Maryland / Department of Health and Mental Hygiene 2 03689 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 Feb. 9:45pм **Physician** Η. Hutson Dolores 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore 138 N. Kenwood Ave. n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec. 24, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min. Days 1 □ M 2 STF T934 69 Director 115-26-6377 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be rutified at 1 ☐ Yes 2 ☐ No Baltimore Baltimore MD Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? USA 21224 Kenwood Ave. Funeral 138 N. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: Specify Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) own home Homemaker 12th permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any njury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillian D. Thompson John Howard Hutchinson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Woodsman Court Baltimroe Maryland William Hutson /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/04 Baltimore MD Holy Redeemer \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 or complications that caused the death Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or co shock, or heart failure. List mot enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition METAS OVARIANO TATIC **Physician** +2 MONTE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to infilted late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division of Vital Records, P.O. Box 68760 burial-transit Due to (or as a consequence of): Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No. Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) P 2 ER/Outpatient funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) nours after 4 ☐ Homicide Hospital or thin 24 hours a the Funeral L filled tiretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the e within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ၀ 10 30. Name and address of person who completed classificated (Item 23a) (Type, Print) 32. Registra Signature 31. Date filed (Month, Day,-Year) State Registrar 1 0 2004

**ORIGINAL** 

			1 - For State RegistrarAMEND ITEN: #5,	State of Maryland 8.19b&20a-c PER FI			Mental Hygie	6004	03690
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las	How	ard	City, Town, or Location of Dea	January	Day Year 30, 200	3. Time of Death 4 16:25 P M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give Strong	cialty Hospita	al l	Baltimire nder 1 Year   If Under 24 Hr	s. 8. Date of Birth	NA	hplace (State or Foreign untry)
		tor	Usual Residence of Decedent  10a. State  10b. County	A Toc. City	7, Town or Location	1000	per 19,1940		10d. Inside City Limits 1 ⊠Yes 2 □ No
	within 72 hours alter death with the Maryland ene. than "natural", or itame 23s or 28e-f show the Madical Examinar must be notified at	Funeral Director	10e. Street and Number 3507 Cople	12. Was Decedent Ever in U.S	S. 13. Was D	Zip Code  2/2/5 ecedent of Hispanic Origin? (	Specify Yes or No-	Citizen of What Co	
الم 215-0036	72 hours atter d "natural", or Itam idical Exeminer	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes,	specify Cuban, Mexican, Pue es 2 🗖 No Specify:	rto Rican, etc.)	Specify: B	lack
2 7	e filed within 72 if Hygiene. other than "na vent, the Wedic	Completed	(Specify only highest gra-	Callege (1-4or 5+)	(Give kind of life. DO NO	f work done during most of with the part of the part o	orking ame (First, Middle, Maid	Priva	te
√ Delu Maryland	2 should be and Mental is marked of eumatic eve	To Be	Russell C	11/ 11	19b. Mailing Add	Beat ress (Street and Number or F	rice Sc	arbore	DUG h
fuvard altimore, N			20a. Method of Disposition  XX Burial 2 Cremation 3 Comparison 4 Donation 5 Other (Specify	Removal from State	3507 COI lace of Disposition ( emetery, crematory) RAINE PARK (	or other place)		Salto	Town, State
Ho.	permit. Page Department of Importent: If any injury or QDCE.		21. Signature of Funeral Service Licen  23a. Part). Enter the disease, or comparisons, or heart failure. List only	L. Russ	22. Name Jose 2227	e and Address of Facility  Ph. L. RUSS  W. North Ave	Funeral Raito.	Home nd. Zizi	Approximate Interval Between
	Pnysician /Medical Examiner	0	short, or heart fathure. List only of immediate Cause (Final disease or condition resulting in death)	a. Restrictive  Due to (or as a consequence)	lun	g disease			Onset and Death
8760,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, 1 ay, ward of the dialecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (ar as a consequence of the consequence o	array	it als fort	4		6 Wacks
P.O. Box 68	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Onknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetel 4 Pregnant at time of de	death 3 Ectop	ic pregnancy r (specify)		23d. Date of deli Month	ivery Day Year
ords, P.	v requires that tl been signed by should be detac	þ	Part II. Other significant conditions or	ontributing to death but not resu	ulting in the underlying	ng cause given in Part I.		2 □ No 3 □ Pro	the cause of death?
al Reco	iicien: The law r certilicate has be rector, page 2 sh	e Completed	25. Was case referred to medical			GC Bloom of D	24a. Was an autopsy performed 1 Yes 2 2	24b. Were au prior to death? No 1 Tyes	topsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely tilled in by the funeral director, page	To B	ovaminar?	(Month, Day Year)	ER/Outpatient 3 28b. Time of Injury		Home 5 Residence		pity)
Divisi	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely tilled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	")		28f. Location (Stree City or Town, St	tate)	
	the Hosi in 24 ho the Fund optietely t	Medical	(Check only 2 Medical Examone)	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	ion and/or investiga	ation, in my opinion, death occ	curred at the time, date	and place, and due	to the cause(s)
	With To 1	2	29b. Signature and title of certifier  CPKebta U	w		29c. License number  D 3 4 9 7 4	29d.	Date signed (Month	2004
_			→ Chebta V  30. Name and address of person who compared to the CHARU MEHTA	completed cause of death (Item	23a) (Type, Print)	slas street.	Baltimore	2, 4021	230
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture hour				

			For State Registrar	State of Maryland		artment of H rtificate of L		ental Hygiene	71111	03691
_ 7F,	7 pt1-1		Decedent's Name (First, Middle, Last)				2	2. Date of Death Month Da	y Year	3. Time of Death
	Physicia Medic		ROSA LEE H	IAMLET				February		
	Examin	er	4a. Facility Name (If not institution, give st				Location of Death	40	. County of Deat	n
	10.36	ž.	Gilchrist Nurs  5. Social Security Number 6. Sex	ing Home	ast birthday)	Balt ff Under 1 Year	imore If Under 24 Hrs.   8	B. Date of Birth	9. Birt	hplace (State or Foreign
-7-	Funeral Director			M 2√2 F 83	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Year)	120 S	Carolina
			Usual Residence of Decedent							
	show	<b></b>	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-1 s	octo	Md Baltimo	ore	Cato	nsville		100 6	tizen of What Co	
	with ti	ă	10e. Street and Number	7		10f. Zip Code	4000	10g. C1		
	eath	erai	36 Clinton Hil.	2. Was Decedent Ever in U.	S. 13. 1		1228 ispanic Origin? (Spec n, Mexican, Puerto Ri	ify Yes or No-	U.S.	ncan Indian,
21215-0036	4 within 72 hours after death with the Maryland Jien. 1 than "natural", or Itama 23a or 28a-1 show The Mauscal Examiner must be notified at	by Funeral Director	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2√∑ No ff Yes, Give Year or Dates:		lf Yes, specify Cuba 1 □ Yes 2 ☑ No	n, Mexican, Puerto Ri Specify:	ican, etc.)	Black, White Specify: B	e, etc. lack
20	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation during most of working )	16b. K	(ind of Business/	Industry
2	within sene then "s	npie	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		po NOT use retired sekeeper	·		Domest	ic
12	filed w Hygier other th		17. Father's Name (First, Middle, Last)		nous	ereeber		First, Middle, Maider	Sumame)	
anc	e de la	) Be	Nathaniel McDo	nald				McAllist		
Maryland	d 2 should the and Men (7 is marke traumatic	은	19a. Informant's Name/Relationship (Typ		19b. Mailie	ng Address (Street	and Number or Rural			Zip Code)
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Cynthia Hamlet		36 (	Clinton	Hill Cou	rt, Balt	imore,	MD21228
Je,	ss 1 an of Heal Item 2 other	. 1	20a. Method of Disposition		emetery, crei	sition (Name of matory or other plac	Da Da		ocation - City or	
Ĕ	Page nent o ant: If ury or		1 ∑Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State WC			ery 2/11			
Baltimore,	permit. Pages in Department of Hamportant: If Ite eny Injury or ot once.		21. Signature of Fifnedal Service Licens	owed &	. 46	2. Name and Addres	erty Heig	ell Fune hts Aven	ral Ho	me
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death a cause on each line.	. Do not ent	er the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resufting in death)	Due to (d as a consequ		tie C.	mccr			Onset and Death
	Examiner	10	Sequentially list conditions, b.	Due to (or as a conseq	vence of):					
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury	200 (0) (0) 20 200 (0)						
Ć,	ate be executed thysicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequent	uence of):					
8760,	ate be hysicie the bur	cal	d							
9	ntifica ng ph a as th		IF FEMALE:							
O. Box	The law requires that the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
۹.	es that If igned by be detac	by Pr	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	w require been sig should b							1 ☐ Yes 2	100 3 □ Pr	robably 4 Dunknown
Vital Records,	The law requate has been page 2 should	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
ital		Bec	25. Was case referred to medical examiner?				26. Place of Death			
of <	S D	10	1 □ Yes 2 No		ER/Outpatie		4   Huising Hom	e 5 Residence	6 Other (Spe	city) to the
	ding h. After fune	atlon:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat 28 k? Yes 2 ∐No	3d. Describe how inju	ry occurred	9
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - AI ho building, etc. (Specif		reet, factory, office	28	Bf. Location (Street a. City or Town, State		ural Route Number,
18	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edicai (		ician: To the best of my kno er: On the basis of examina and manner stated.						
)	Vithii Vithii	Σ	29b. Signature and title of certifier	They, in	w	D2			SYUBY	n, Day, Year) G, 2004 (20
	- N		W.A. Roles	mpleted caus of leath (Item	670	Print) N. C	huly St	- Bolto.	m 2	120
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		1				
DH	Regist MH 17 Rev 1/2		FEB 1 0 2004	par new p	for	sarks				

ORIGINAL

HmiET, Rosalee

		•	For State Registrar	State of Ma	-	epartment of F Certificate of			iene g. No. 200	03692
	5 a 4 3		1. Decedent's Name (First, Middle, Last	)	,	1		2. Date of Deat	h Day Yea	3. Time of Death
	Physici /Medic		Dian			tamis		February	1 5 200	4 03:50 "
	Examin	32.	4a. Facility Name (If not institution, give	)		4b. City, Town, o	r Location of Deat		4c. County of D	
		136 . A	5. Social Security Number 6. Se	myview 7 Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs		N,	A  Birthplace (State or Foreign
	Funeral Director		217-34-7604	TM STXE	66 Y	Months Davs	Hours Min.	8. Date of Birth (Month, Day, OCT 25	Year) 1937	Maryland
	D		Usual Residence of Decedent						, 1,0,,	
	show	_	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1X Yes 2 □ No
	Ne M	Director	Maryland N/A			Baltimore 10f. Zip Code		10	0g. Citizen of What	
	with a or	급	4304 Nicholas	Avenue			1206		US	•
	ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H		Specify Yes or No-	14. Race - A	merican Indian,
36	d within 72 hours after death with the Maryland jiene. Ir than "natural", or Items 23a or 28e-f show the Madical Examiner must be mulliad at	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give	•	1 ☐ Yes 2M No		to rican, etc.)	Specify:	Thite, etc.
21215-0036	hours tural		3 ₩ Widowed 4 □ Divorced  15. Decedent's Edi	Year or Dates:	16a. D	ecedent's Usual Occup	pation		16b. Kind of Busine	White ss/Industry
15	n na Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(	Give kind of work done ife. DO NOT use retire	during most of wo	orking -		,
212	giene.	E	10	Conego (1-40) 34	<b>'</b>	Homemaker			Own I	Home
pu	be filed tal Hygir d other svent, I	Be	17. Father's Name (First, Middle, Last)	•				me <i>(First, Middl</i> e, M h Heim	Maiden Sumame)	
Z Za	2 should be and Mental Is marked o	ဥ	John C. Kuhi		10h I	Mailing Address (Street			City or Town State	a Zin Code)
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 Is marked othe other traumatic svent,		Ruth Murphy/daugl			014 Pinehur			e, MD 212	
re,			20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other place	сө)	Date	20c. Location - City	or Town, State
E	Pages nent of ant: If it		1 ☐ Burial 2 X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)			Crematory,		9/04	Baltimo	ce, MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of European Service License Lice	!ww		Cremation 299 Frede				
		V.	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused t	the death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Cardio	1	chemia				Onset and Death
	/Medical Examiner		resulting in death)		consequence of					
10 m	- Addition of	_	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. Hemi	consequence of	):				1 aay
	uted I Insit	Examine	Cause (Disease or injury	Acuto	100	norrhode	)			Iday
ó	death certificate be executed e attending physician and by for use as the burial-transit		that initiated events resulting in death) Last	C. Due to (or as a	consequence of		and the same of th			T. Carry
8760	ate be nysicia he bu	dical		d						
9	artifica ing ph e as ti	Med	IF FEMALE:							
Вох	death certifica attending ph d for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1□Live birth 2 4□Pregnant at t	Fetal death	3 Ectopic pregnance 5 Other (specify)	у		23d. Date of Month	delivery Day Year
o.	at the de by the a tached	yslo	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9 Unknown	into or death	3 Giller (specify)				
٩,	g pe	by Pt	Part II. Other significant conditions co	entributing to death bu	t not resulting in	he underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute	e to the cause of death?
rds	w requires to been signed should be							1 □ Ye	s 2∭ No 3⊡	Probably 4 Unknown
Vital Records,	0 - 0	Completed						24a. Was ar autops perform 1 X Yes 2	y prior	autopsy findings available to completion of cause of ?
ital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on		
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 X No	Hospital: 1 X Inpatier	7	alient 30 DOA		Home 5 Reside		pecify)
		<u></u>	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	ury Wo	ryat rk? ]Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	deat deat ctor: y the	flcat	2 Accident investigation 3 Suicide 6 Could not be			n, street, factory, office				Rural Route Number,
Ö	el or A s after al Dire	Certification:	4 Homicide	building, etc.	. (Specify)			City or Town	i, State)	
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E	Medical			examination and	death occurred at the ti for investigation, in my t				
	To the To the complet	M	29b. Signature and title of certifier	6		29c. Licens	se number	2	9d. Date signed (M	onth, Day, Year)
)	$\wedge$		4.18Cc			K	1-00	0	2/6/0	7
	2		30. Name and address of erson who c	completed cause of de	ath (Item 23a) (T	ype, Print)	2000	Baltin	no m	No mod
	Sta	ate	31. Date filed (Month, Day, Year)	\$2. Registra	r's Signature	JUSTO ALI	TURE	Dull!	101 111	0 2 0 7
	Regist		FFR 1 0 2004	fen	M. A.	134/19				

			1 - For State Registrar	State of	Maryland / D	epartmer Certificat			and M	ental I		ene 20	0	03693
			Decedent's Name (First, Middle, Last,	)	-					2. Date of	f Death		V	3. Time of Death
	Physici		Patricia	Helen 1	Haydock					Month FEB	_	Day 200	Yeer )4	7:30a M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location o	f Death			4c. County	of Death	
			351 Broadview Lar	ie			Anna	apolis	3			Anne	Aru	ndel
	Funeral		5. Social Security Number 6. Sec		Age (In yrs. last birt	hday) If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date o	Birth Day, Y	(ear)	9. Birthp	lace (State or Foreign
н	Director		031-18-0330	M 201F	78	rs.	,-			AUG	13,	1925		sachusetts
	put		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							1	0d. Inside City Limits
	laryig •ho	č		1 1			٠.							1 ☐ Yes 2 No
	the N	Director	Maryland Anne Ar	mider			ipoli	S			100	. Citizen of W	/hat Cour	atry?
	with	<u></u>	570 Bellerive	Drive	Apt. 237	101. 21		401			.09	USA	mar oo a	,.
	leath	Funeral	11. Marital Status	12. Was Decede		13. Was Dece If Yes, spe			gin? (Spec	cify Yes o	r No-		- Americ	an Indian,
10	r iten	표	1 ☐ Never Married 2 ☐ Married	Armed Force	as? No				, Puerto F	Rican, etc.	)	Black	k. White,	
ဗ္ဗ	urs a	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Date	os:	1 Tes	2U No	Specify:				Specify:	W	nite
20	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Espiriter round be notified.	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Usu (Give kind of wo	al Occupa	ation furing most	of workin	ia.	16	b. Kind of Bu	siness/In	dustry
2	thin thin we	nple.	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO NOT	se retired	)		9				
7	ed w ygjen t. In	Co		4		Nurse						Heal:		re
pu	tai H d oth	Be	17. Father's Name (First, Middle, Last) Walter Yankows	ki								iden Sumam	,	
$\frac{2}{3}$	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Estatricer marked collified at	ဥ			4 .17		/=-					reniti		
Maryland 21215-0036	12 sh h and 7 te n rraun		19a. Informant's Name/Relationship (Ty			Mailing Addres								Code)
e,	1 and Health em 27 ther tr	1 9	Valerie Jean Leit	zer/daug		1 Broad		Lane		lapol ate		MD 214 c. Location - 0		wn. State
ية	Pages nent of I int: If its		1 ☐ Burial 2 ② Cremation 3 ☐ F	lemoval from Sta	cemeter	crematory or Cremato	other place		2/7/	04		Baltim	,	
Baltimore,			* 4 □ Donation 5 □ Other (Specify)  21. Signature of Fun-ral Selection of the selection of	A77	TICCLO			1110.						110
Ba	permit. Departr Imports any inj			MINUCK		Cremat	ion	Socie	ty o	f Mai	ryla	nd, In	С.	2.0
			23a. Part1. Enter the disease, or compl	LCI ications that cau	sed the death. Do n	ot enter the mod	eder	1CK R	oad cardiac or	Ball respirato	LMO:	re, MD	212:	Approximate
	A 5		shock, or heart failure. List only or Immediate Cause (Final	ne cause on eac	h line.	١			1.1					Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to /or	as e consequence	RE SA	Tuc	un	101	wy.				4 weeks
	Examiner			D 40 10 (01	as a consequence of	17.								
	7	je.	Sequentially list conditions if any, leading to immediate	Due to (or	as a consequence of	t):								
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o o	an an	Ex	resulting in death) Last	Due to (or	as a consequence o	f):								
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcai		j								·		
ဖ	ng ph	Med	IF FEMALE:											
Вох	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p						23d. Date Mon		ry Day Year
0	the at	Physician/Me	1 Yes 2 No	4□Pregnan 9□Unknow	t at time of death n	5 Other (s)	oecify)				_			ou, rou.
P. 0.	that the de led by the a detached t	F.	Part II. Other significant conditions cor	atabuting to deat	h but not resulting in	the underlying	alica cive	n in Part I		23e F	id tobac	co use contri	bute to th	e cause of death?
Division of Vital Records,	signed be de	by	Turin out organical contains on	in bothing to doub	Darrior roodining	and directlying	2200 g.re							ably 4 Unknown
Ö	w require been signatured should t	etec									100			
ဒို	hasl hasl	Completed								а	Vas an utopsy erforme	DE	rere autor rior to cor eath?	osy findings available inpletion of cause of
a												No 11		2 No
Ħ	Physician: r this certificinal director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	atient 2 ☐ ER/Out		Othe	26. Place				V	10 1	daughter's
ō	Phys r this sral dii	$\vdash$	1 ☐ Yes 2 No  27. Magner of Death	1 ☐ Inpa	njury 28b. Ti		28c. Injury	at Nur	sing Hom			injury occurre		residence
on	tding th. : Afte	타	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year) In	jury M	Work	.? ∕es 2 🗆 N	No					
/IS	Attendir death.	ifica	3 Suicide 6 Could not be	28e. Place of	Injury - At home, fan	m, street, factor	y, office		21				r or Rura	Route Number,
	al or A s after il Dire	Certification:	4   Hornicide	building,	etc. (Specify)					City or	Town, S	olate)		
	To the Hospital or Attending Ph within 24 hours after death.  To the Funaral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the be	est of my knowledge,	death occurred	at the tim	e, date and	place, ar	nd due to	the caus	e(s) and man	ner as st	ated.
	he H in 24 he Fi plete	edical	one) 2 medical Examin	and manner	stated.		i, in my op	nnon, deau	n occurre	or act the cir	ne, care	and place, at	IG GUÐ IÓ	the cause(s)
	To I To I	Σ	29b. Signature and title of certifier	)		29	c. License		. ^ _	,	29d.	Date signed	(Month, I	Day, Year)
•	^		1 you a lit			-	DO	060	240	0		16/	04	
	5		30. Name and address of person who co					D- "	E0E1	n. 1.		300	01.00	7 0002
			Kristy L. Weber,		01 N. Card	oline St	reet	Km #	0451	Balt	1mo	re, MD	2128	07-0882
	Sta Registr	-	31. Date filed parting Day, real 2004	SZ. Heg		a State of								

*			For State Registrar		State of	f Marylar	•	artment rtificate				ental Hy	giene 0	04	0369	94
	Physicia /Medic		1. Decedent's Name (First, Midd Will		LR.	HERA	tal			-		2. Date of De. Month TEBRU	Day	Yeer &O4	3. Time of Dea	ath 4 M
	Examin		4a. Facility Name (If not institution	n, give str	eet and nun			4b. City,		Location of	/		4c. County	of Deeth	one Pr	ч
	Funeral Director		5. Social Security Number	6. Sex	4 2□F	7. Age (In yrs. 78	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Sept.	y, Year) 8, 1925	9. Birthpl Count Mary	lace (State or Fo try) yland	oreign
out of	f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Balti			10c. Ci	ly, Town or Lo		timo	re				10	0d. Inside City L	
1	3e or 28a-	il Director	10e. Street and Number 3530 Meadowsio	le Av	enue			10f. Zip	Code	21207	7		10g. Citizen of W Unites			
5-0036	permit. Pages I and 2 should be mad writin for hours arise death with the waryfall binportent of Health and Mental Hygiene. Importent if item 27 is marked other then "natural", or iteme 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinat must be notified at 000s.	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Mai  3 □ Widowed 4 □ Divorce	ried	. Was Dece Armed Fo 12 Yes If Yes, Giv Year or Da	odent Ever in Urces? 2 No WWI ates:	.S. 13.	Was Deced If Yes, spec		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		e-America k, White, e : Whit	etc.	
121	giene. pr than "natu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12			-4or 5+)	16a. Dece (Give life. Admin	dent's Usua kind of wor DO NOT us istra	k done d se retired,	luring mos )	t of worki	ng	16b. Kind of Bu		·	
ם	should be fried with and Mental Hygiene. I marked other than umatic event, then	To Be (		Burto		ran				F	Emily	e Mar	Maiden Sumami ie Mill	er		
	Health and early services the services of the		19a. Informant's Name/Relation Shirley Horan	ship <i>(Typ</i> e		ister	3530	Mead	owsi		oad,	Gwynn (	or, City or Town, . Dak, MD	21207	7	
3altimore,	Definit. Pages 1 at Department of Hea Importent: If item eny injury or othe once.		20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (:		noval from	State	Place of Dispo cemetery, cre iew Me	matory or o	ther place	1		lary 7,	20c. Location - 2004 Sy	·		D
Balt	Departr Departr Import eny inji		21. Signature of Funeral Service	) Ka	Que	4003	23 8	728 L	iber	ty Ro	l., F	landall:	rs Funer stown, M			
60,	Physician and Medical American and Physician	ical Examiner	23a. Park, enter the viseas of sheet, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Little Unide lying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Due to (	ach line.	quence of):			y, such as	Cardiac	пезупасоту а	1031,		Approximate Interval Betwee Onset and Dea	
Box 6	dean cermic e attending pt id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	230	1 Live b	come of pregn irth 2 Peta ant at time of cown	ideath 3	□Ectopic pri □ Other (spi					23d. Date Mor	e of delive	ry Day Yea	ır
ords,	v requires been sign should be	þ	Part II. Other significant condit	ions contr	_	eath but not res	sulting in the u	inderlying c	ause give	en in Part I				3 Proba	ably 4 □Unki	nown
	certificate has b rector, page 2 sl	e Completed	25. Was case referred to medic	al						00 8100		autor perfo 1 ☐ Yes	2010 1	leath?	osy findings ava npletion of caus 21210	ie of
-	To the Hospites of Attending Proyactions, within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	To B	examiner?  1 Yes 2 D No  27. Manner of Death  1 Natural 5 Pend 2 Accident inves	Ho ing tigation	28a. Date		ER/Outpatie 28b. Time o Injury	97.0	8c. Injury Work	er: 4 □ Nu	ursing Ho		dence 6 Othe		")	
Division	rs after de al Directo	Certification:	3 Suicide 6 Could 4 Homicide deter	not be nined	28e. Place buildi	of Injury - At h ng, etc. (Speci	ome, farm, st fy)	reet, factory	, office		Control	28f. Location (: City or To	Street and Number vn, State)	er or Rura	l Route Number	τ.
	ne Hospi n 24 hou he Funer pletely fill	edicai	29a. Certifier 1 Certify (Check only 2 Medica	ng Physic	r: On the b	best of my kn asis of examina ner stated.	owledge, dear ation and/or in	h occurred ivestigation.	at the tim , in my op	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)	
	withi To the	W	29b. Signature and title of contri	Per	46	3	MD			number 95	02		29d. Date signed			W
	8		30. Name and address of person	who con	Con	Lanton	1 112	Print)		PHA	2066	COUN	HOSPIE, man	4L UCA	C=07	33
	Sta Regist		31. Date fited (Month, Day, Yea	004	/32. R	legistrar's Sign	ature	Res .				,		7		

			Tiedse i	State of Mary	/land / Depa	artment of I	Health and M	-		03695
			* Registrar		Cei	rtificate of	Death		g. No.	00000
П	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Edwin Phillips		· · · · · · · · · · · · · · · · · · ·			February		11:30 P <sup>M</sup>
7	Examin	er	4e. Fecility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Dee	
			11008 Baronet Roa	d		Owings If Under TYear	Mills		Baltimo	
П	Funeral		5. Social Security Number 216-14-8954 6. Sec	7. Age (fr 12M 2□F   83	n yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 14,	Year) 9. Bir	thplace (State or Foreign
	Director				115.			June 14,	1920 80	ston, Mass
	and *		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	sho	ō			•					1 ☐ Yes 21 No
	788-1-88	Director	Md Baltimor  10e. Street and Number	e (	OwingsMil	10f. Zip Code		10	g. Citizen of What Co	ountry?
	di p	ក្ន	11008 Baronet Road			21117		10	-	out it y i
	within 72 hours after death with the Maryland ene. than "natural," or Itams 23s or 28s-f show the Modical Exemples mail the modified at	Funeral		12. Was Decedent Eve	rin II C 12		Hispania Origin? /Sr	nacifu Vac or No	USA 14. Race - Ame	ancen Indian
	er de Itam ner	Ě	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No	1941-	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whi	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1943	1 ☐ Yes 2 🏻 No	Specify:		Specify: W	nite
Ş	hou	ed	15. Decedent's Edu		16a. Dece	dent's Usual Occu	pation		6b. Kind of Business	/Industry
15	in 72 n" c	olet	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of world)	king		
2	with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Inv	vestment	Banker		Financia	a1
0	illed w Hygier other th		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
an	ould be Mental arked o	To Be	Harold Grant Hatha	away			Louise I	Phillips		
Maryland 21215-0036	shoul mari	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Stree	t and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
<u>s</u>	nd 2 string transfer		Barbara M. Hathawa		11008	Baronet	Road, Ov	vings Mil	ls, Md 21:	117
a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner matter notified at ODGe.		20a. Method of Disposition	12	20b. Place of Dispo	sition (Name of		Date 2	0c. Location - City or	Town, State
Baltimore,	Pages nent of I int: If its ury or o		1 ☐ Bunal 2 X Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Carroll 1	cremation	ເຮື 2/09,	/2004	Hampstead	, MD
₹	iit. P		21. Signature of Fylleral Service Licens	88 - 0	22	2. Name and Addr	ass of Facility			
Ba	permi Depa Impo any ir		JAH-IB		E	line Fun	eral Home	11824 Re	isterstow town Md 2	nıRgad
	-		23a. Part1. Enter the disease, or compl	ications that caused the						
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		_	_			Approximate Interval Between Onset and Death
	Physician // // // // // // // // // // // // //		disease or condition resulting in death)	i	scher	nic	Car	Klom	y o patu	>
塘	Examiner			Due to (or as a co	onsequence of):		60 .	1 20050	0000	
П		<u>.</u>	Sequentially list conditions,	Due to (or as a co		mic	new	1 acs	15/	
	pe d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	Alsequence on.					
	and I-trar	хап	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
760,	ie be executed ysician and e burial-transit	calE		500 10 (0. 20 2 00	311304301100 01/1.					
687	9 2 0			1						
9 ×	Attending Physician: The law requires that the death certifical or death.  • closul.  • closul. After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Medl	IF FEMALE:	3c. If yes, outcome of p	rennancy				224 2-1-14	
Вох	atten atten for us	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnand	у		23d. Date of de Month	Day Year
o.	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	eordean 5L	Other (specify)	· · · · · · · · · · · · · · · · · · ·			
۵.	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions cor	stabuting to death but a	ot resulting in the u	nderhing cause of	ven in Part I	23e Did tobs	acco use contribute to	the cause of death?
JS,	ires t signe		- Latin			ndonying dadoo g.				obably 4 Junknown
0	neen	tec							7 2 3 10 3 3 1	
ec	e law has b	nple.						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	The cate t	Completed						perform		2. No
Division of Vital Records,	cian: ertific	Be	25. Was case referred to medical examiner?					th (Check only one	)	
$\leq$	hysic his c	၉	1 ☐ Yes 2 ☑ No		2 ER/Outpatier	" 3 DOA			ice 6 ☐Other (Spe	city)
0	ng P fter t		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o lnjury	f 28c. Inju Wo	ry at rk?	28d. Describe how	v injury occurred	
<u>s</u>	endi eath. or: A	ati	2 Accident investigation			M 1	]Yes 2 □No			
Ë	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	ital c irs af ral D led ir									
	tosp t hou une une sly fil	cal	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of m	ny knowledge, deat	h occurred at the ti	me, date and place,	and due to the cau	use(s) and manner as	stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	and manner stated						
	To To Co⊓	2	29b. Signature and title of certifier			29c. Licen			d. Date signed (Mont	n, Day, Year)
	11		1 135			DOC	2526		2/7/09	
	me,		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type,	Print)	2526 Charl	1		_
-	c+		David Ber	liner	656	N. 6	new	es >1	1000	on 21204
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature					
	Registr	ar	FFR I 0 200	A feeten.	11 6	ach o				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kari L. Harrel1 February 4 2004 5:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4107 Doris Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 20, 1 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F 216 68 4744 47 Yrs. ĩ956 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1⊠Yes 2 No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4107 Doris Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after dail Hygiene.
other than "neturel", or Item I □ Yes 2 ▼No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 XI Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: If Item 27 is marked other the any Injury or other treumelic event, 12 space. 12th Data Entry Appraisal Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Wesley Gardner ဂ Mildred Aline Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Harrell / Daughter 3823 Mount Pleasant Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 2/5/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part1. Enter the disease, or conshock, or heart failure. List only olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bea /Medical Examiner mo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a donsequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has be ral director, page 2 s autopsy performed 1 Yes 2/2 No 1 Tyes 2 □ No To the Hospital or Attending Physicien: 25. Was case relerred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Thomicide 24 hours a e Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6. 31. Date filed (Month, Day, Year) 3001 anoven 32. Registrar's Signature State Registrar

KKD		•	1 = For Unpend Item #2:	State of Mar Ba &27 per me (	yland / Der 3828 2/26/	artment Prtificate	of H	ealth a Death	and M	lental Hy	gien Reg. N	and the Co	04	03697
	Dhi-i-i		Decedent's Name (First, Middle, La							2. Date of De		ay	Yeer	3. Time of Death
	Physicia /Medic	_		Laura Mar	ie Hoope	r				FEBRUA	RY	i, 20	04	10:33A. M
	Examin		4a. Fecility Name (If not institution, giv			4b. City, T	own, or	Location	of Death		4	c. County	of Deeth	
0			104 OAK SPRINGS D 5. Social Security Number 6. S		In yrs. last birthda			BURNI If Under		8 Date of Bi		NNE A		
53	Funeral Director			- 3f -	5 Yrs.		Days	Hours	Min.	8. Date of Bi (Month, D July 2	ay Yea	1958	Cour	lece (State or Foreign htry) y land
(,)	70		Usual Residence of Decedent							7				•
	how	_	10a. State 10b. County		0c. City, Town or I								1	0d. Inside City Limits
	8a-1 o	Director		rundel	Glen B									1 ☐ Yes 2 🗖 No
	with the or 2		10e. Street and Number	Dudas		10f. Zip (		-0			10g. C	itizen of W		itry?
	72 hours after deeth with the Maryland naturel', or Iteme 23a or 28a-f ehow disal Examiner must be nutified at	Funeral	104 Oak Spring  11. Marital Status	12. Was Decedent Eve	er in U.S. 13	. Was Decede	2106 ent of His	spanic Or	igin? (Sp	ecify Yes or N	0-	U.S.		an Indian.
ဟ	or Iten		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 📆 No		If Yes, speci	fy Cubai	n, Mexicai	n, Puerto	Rican, etc.)			c, White,	
93	ret', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Yes 2	M No	Specify:				Specify:	Whi	.te
5-0	72 h	Completed	15. Decedent's E (Specify only highest gra		(Giv	edent's Usual e kind of work	done d	luring mos	at of work	ing	16b.	Kind of Bu	siness/Ind	dustry
121	within ane.	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT</i> use itress		)			Н	lote1		
20	filed v Hygie ther i		12th 17. Father's Name (First, Middle, Last	)				18. Mothe	er's Name	e (First, Middle			e)	
an	id be ental ked o	To Be	Frank J	. Robbins					Car	ra P. I	3roc	ks		
ary	shou ind M ind M umar	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	ling Address	(Street a	ınd Numb	er or Rura	al Route Numb	er, City	or Town, S	State, Zip	Code)
Ž	atth a		Michael Hooper	/ Husband	104	Oak Sp	ring	g Dri	ve	Glen I	3urn	ie, M	aryl	and 21060
ore	of He fitem roth		20a. Method of Disposition  1  Burial 2  XCremation 3		20b. Place of Disposemetery, cr	osition (Namematory or other	e of her place	9)	[	Date	20c.	Location - (	City or To	wn, State
Ĕ	Peg ment ant: h		'4 Donetion 5 Other (Special		Bayview		<u>-</u>		2/5/	2004	Ba1	Ltimo	ce, N	Maryland
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturet", or Iteme 23a or 28a-1 ehow eny injury or other treumatic event, the Medical Examinet must be notified at 9068.		21. Signature of Funeral Service Licer	Ramia	//	22. Name and 4001 Ri			O.C	nce Fu				e, P.A. yland 21225
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the	e death. Do not e	nter the mode	of dying	g, such as	cardiac	or respiratory a	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Chronic alo										Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c										
	Lxammer	_	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a c										
	pel list	nlne	cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or):									
	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):									
8760,	e be e	dical	· ·	d.										
98	tificat ig phy as th	led									1			
P.O. Box	The law requires that the death certifi ate has been signed by the attending f page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2 (		☐Ectopic pre	onancy					23d. Date		•
Э.	e dea he att	sicia	in the past 12 months?	4☐Pregnant at tim		Other (spe						Mon	th	Day Year
P.0	d by the	Phy	9 Unknown					a in Book		an- Did	100000			
S,	signe d be d	by	Part II. Other significant conditions	contributing to death but i	tot resulting in the	underlying ca	use give	n in Part i						e cause of death?
0.00	w require been si should I	Completed								-				
3ec	e faw has l ge 2 s	ld m								24a. Was		p	vere auto rior to cor eatb?	psy findings available apletion of cause of
a			OF Western street and deal							Yes	2 🗆 N			2 No
<u>Ş</u>	sicial s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	2 ER/Outpati	ent 3 DO/	Othe			n <i>(Check only</i> me 5 ☐ Res		S.COsho	e (Casait	SCENE
of	Attending Physician: r death. sctor: After this certifica by the funeral director.	<b>-</b>	27. Manner of Death	28a. Date of Injury	28b. Time	of 28	c. Injury	at	7	28d. Describe				) SCHIL
io	Attending F death. ctor: After y the funeri	atlo	1. Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Y	eer) Injury	м	Work	? ∕es 2 🗌	No					
approx eta Division of Vital Records,	or Atte ifter de Directo in by th	Certification:	3 Suicide 6 Could not be determined		- At home, farm, s (Specify)	street, factory,	office			28f. Location ( City or To	Street a	and Numberte)	r or Rura	l Route Number,
<b>U</b>	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Pl	nysician: To the best of miner: On the basis of ex	my knowledge, dec	ath occurred a	it the tim	ie, date ar	nd place, ath occurr	and due to the	cause(	s) and mar	ner as st	ated. the cause(s)
	thin 2 the the mplel	Medical	29b. Signature and title of certifier)	and manner state	d.			number				ate signed		
	To T		6 Clarko	MIN										
	1 / W		30. Name and address of person who	completed cause of the	th (Item 23a) (Typ	e. Print)	0.0	.M.E		<u> </u>	EBR	UARY	2, 2	004
	10 B		J. LARON W	te m	)		enn	Stre	et i	Baltim	<b>17</b> 0	Ma <b>~</b> :	rl and	21201
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	med 3			~ 6 /			- ши	TOLK	CLCV1

			State	of Marylan	•	rtment of h tificate of		d Mental Hy	20	101.	03608
	Physici	an	1. Decedent's Name (First, Middle, Last)	ober		imouto or	Douin	2. Date of De	Day	Year	3. Time of Death 8-30P.N.
	/Medic Examin		4a. Fecility Name (If not institution, give street and r.		0 1		4b. City, Town, o	or Location of Death	7	of Death	8.001
	LXamiii	٥	ROCK Glenn NC	irsing	(ente	2	BaHir	nore	I.	N/A	
	Funeral Director		5. Social Security Number 714-03-4073 6. Sex 1 → M 2 □ F	7. Age ( <i>In yrs</i> . 99	last birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Bird in. Month, Da JUL 23	y, Year) 1904	9. Birthp Coun Mary	elace (State or Foreign etry) yland
	and ow f		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				10	0d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	ţo	Maryland N/A		F	Baltimore	2				Yes 2□No
	th the	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	What Coun	itry?
	ath wi		10 North Rock Glen Ro				21229			JSA	
020	within 72 hours after death with the Maryland ene. ene. then "netural", or items 23a or 28a-f show he Medical Evardiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was De Armed 1 □ Yes If Yes, C	ecedent Ever in U Forces? s 2 ⊉No Give Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Rac Blac Specify	ce - Americ ck, White, c y: Wh	
ה ה	"netur	sted	15. Decedent's Education (Specify only highest grade completed	d)	16a. Deced	ent's Usual Occup	pation	vorkina	16b. Kind of B	usiness/Ind	lustry
7	within 72 hours ene. then "netural", he Medical Exa	Completed		(1-4or 5+)		kind of work done O NOT use retire	d)	Volkung	D :1	Т.	
7 0	e filed v al Hygie other ti vant, th		17. Father's Name (First, Middle, Last)		Cler	K	18. Mother's N	lame (First, Middle,	Railwa Maiden Suman	- 1	oress
ylan	2 should be and Mental is marked of eumatic eve	To Be	Jefferson D. Hooper				Mary	Byers	11.1.1		
, Ma	ges 1 and 2 should be filed withing to Health and Mental Hygiene. If Item 27 is merked other then or other treumatic event, the Mercontal free mercontal fre		19a. Informant's Name/Relationship (Type, Print) Anne Stocksdale/daughter		319 S	tonewal1	Road	Rural Route Number Catonsvi			
altimore	Pages 1 nent of H int: if iter iry or ott		20a. Method of Disposition  1 □ Burial 2 Ă Cremation 3 □ Removal fror 4 □ Donation 5 □ Other (Specify)	morare .		ition (Name of atory or other place ematory,		Date 2/9/04	Baltin	-	
Sall	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee		22. C.r	Name and Addre	ss of Facility	of Maryl	and In	200	
_	80 E 8 8		Thomas Gregor		29	9 Freder	cick Roa	d Baltin	nore, MD	2122	28
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the deat neach line.	th. Do not ente	r the mode of dyir	ng, such as card	liac or respiratory ar	rest,		Approximate Interval Between Onset and Death
-	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	00501	lesof	ic Ca	ndio	Vas (c)	las di	Sesse	Jegis
	ed sit	lner	<b>a</b> b. <b>H</b> C	Due to (c	consequence of the second of t	uence of):			,	i i	Jeans
Š,	tificete be executed g physician and as the buriel-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	or as a consequ	ience of):	stico:	Airung	disa	250	Clear
700	artificete I ing physi e as the t	Medical	resulting in death) Last	Due to (o	or as a consequ	ence of):			1		7
ב ב	ath ce	lan/	d								
	w requires that the death certificate is signed by the attending should be detached for use as	/ Physician/N	Part II. Other significent conditions contributing to	death but not res	ulting in the un	derlying cause giv	ven in Part I.		obecco use con ∕es 2□ No	ntribute to 3 ☐ Prob	the ceuse of death?
ecorus,	The law requires that the death cert attending the best been signed by the attending page 2 should be detached for use	Completed by						24a. Was perfo	an autopsy med?	ava	ere autopsy findings uilable prior to npletion of cause death?
<b>C</b>	The left he page	S						1 D	es 20 No	1 🗆	Yes 2½ No
N I G	icien: Sertific Bector,	Be	25. Was case referred to medical examiner?  Hospital:			Oth		eath (Check only o			
5	Phys	유	TE Tes 200 NO	☐ Inpatient 2☐ te of Injury	ER/Outpatient 28b. Time of	3□ DOA Oth	4 DO Nursing	Home 5 ☐ Resid	ence 6 Oth		)
	ading tth. :: After e fune	at lon	1 A Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	onth, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 20020	,,		
DIVIS	To the Hospital or Attending Physicien: The law within 24 hours effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At ho Iding, etc. (Specif		et, factory, office		28f. Location (5 City or Tow	itreet and Numb m, State)	er or Rurel	Route Number,
	le Hospit n 24 hour le Funera	edical (	29a. Certifier (Check only one) 1X Certifying Physician: To the Amedical Exeminer: On the and ma	he best of my kno basis of examina anner stated.	owledge, death ation and/or inve	occurred at the tinestigation, in my o	ne, date end pla pinion, death oc	ce, and due to the courred at the time, o	ause(s) and ma date and place, a	inner as sta and due to	ated. the cause(s)
	To th COMP	Me	29b. Signature and title of certifier	1.0		29c. Licens	e number		29d. Date signed	d (Month, E	Day, Year)
	X		Amstun W 4  30. Name and address of person who completed car	Latem use of death (Item	MD n 23a) (Type. F	Drint)	5503	3	teb14	gry	04 2004
ðs.			AMOTUNI LLCO	OCO / Registrar's Signa	MD 5	,01 D	olphin	151, 1891	10, M.	DQ	121+
	Sta	ie.	FER I'll 2004 &	La							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 699 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2:45 PM 2004 02 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Sandtown timore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Funeral 1□M 2ØF Days 7 Yrs. 26.9072 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel; or items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examinat must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo more 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21223 Funeral Kington 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 In No Specify. ٥ Specify: 3 Widowed 4 Divorced 1 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) rivate 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pinkney Hona ည Lander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lexington BALtimore, MO21223 11/1am OHNSON IC/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2-10-04 Owines Mills, MD Vaughn C. Green Feneral Services Va Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8728 Liberty Rd Klene Kandalls town 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) CHRONIC PULMONARY DBSTRUCTIVE Examiner Due to (or es a consequence of): Examiner attending physician and for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3⊠Probably 4 ☐ Unknown DEMENTIA Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? should 24a. Was en eutopsy performed? page 2 s certificate has 1 ☐ Yes 200No 1 ☐ Yes 2 ☐ No ours after death.

erel Director; After this certifical filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA ٩ 1 ☐ Yes 2 🔼 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 27. Menner of Death Certification: 28d. Describe how injury occurred 1 Naturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a

To the Funerel C

completely filled to the bast of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier D0059107 02-06-2004 M. D 2600 LIBERTY MEIGHTS AVENUE 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Registrar

State

UMA

31. Dete filed (Mortin P. Year)

CENTER

BALTIMORE, M.D 21215

MEDICAL

32. Registrer's Signeture

WESTSIDE

2004

		-	For State Registrar	State of Maryland / D	epartment of H Certificate of L			ene 2004	0.70
	Dhysisis		1. Decedent's Name (First, Middle, Last)	115 - 21			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -		NSON	4. C: T	Lacation of Dooth	02	4c. County of Deeth	7:00 AM
	Examin	er	4e. Facility Name (If not institution, give s	YIAND MEDICAL SY:	4b. City, Town, or BALT	IMORE,!	UD	NA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) tf Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
i -	Director		L10-11-617	[M 2□F 84 Y	rs. Month's Days	riours will.	(Month, Day, Y	719	mo
	and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryl	ţō	MD NA	BALTIM	IORE				1  Yes 2 □ No
	h the	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	ath wil	ralD	1100 PENNSYLVA		212	D	- 4. W N-	14. Race - Ameri	ean Indian
	er des	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 (X)Yes 2 □ No	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Bleck, White	
036	urs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔼 No	Specify:		Specify: 82	ack
5- 0-	72 ho	Completed by	15. Decedent's Edu (Specify only highest grade		Decedent's Usual Occupa (Give kind of work done of	luring most of worki		b. Kind of Business/Ir	ndustry
121	within iene. then	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	)		HOTEL	
d 2	be filed within 72 hours after death with the Maryland all Hygiene. Id Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 20a or 28a-f show event. The healiful Examiner must be notilised at	e Co	17. Father's Name (First, Middle, Last)	N	VOTITION	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>lan</u>	ould be Mental arked o	To Be	HARRY JACKSON			VIRGIE	JOHNS	N	
lary	and and sm		19a. Informant's Name/Relationship (Ty		Mailing Address (Street a	and Number or Rura	A Route Number, C	City or Town, State, Zi	
e,	1 and 2. Health ac lem 27 is		PEGGY HARGROVE 20a, Method of Disposition		Disposition (Name of	RESI AVE	Date 20	oc. Location - City or T	1D 21209 own, State
nor	Pages nent of h int: If its iry or o		1 🛱 Burial 2 ☐ Cremation 3 ☐ F  *4 ☐ Donation 5 ☐ Other (Specify)	cemeten	y, crematory or other plac	02-10	4	-12	ILLS, MO
Baltimore, Maryland 21215-0036	그 된 원 중 .		21. Signetian of Funeral Service Licens	9000	22 Name and Address VAUGHN C. G				1000 1110
Ö	Depa Impo eny ii		Vangh C	<u></u>	18128 LIBERT	4 RD., BA	NOAUSTON	NN MD 2	1133
# ***			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the death. Do not not cause on each line.	ot enter the mode of dyin-	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA	0				1 WEEK
Н	Examiner			Due to (or as a consequence of CONGESTIVE		-AII URE	=		1 YEAR
	6 <sub>16</sub> - 6	Jer	Saquantially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of		AILUICE			
	ocuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	.0.				
60,	the death certificate be executed y the attending physician and Iched for use as the burial-transit		resulting in deathy cast	Due to (or as a consequence of	31):				
09289	ficate be ex physician s the buria	edical		1.					
Box (	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐Ectopic pregnancy			23d. Date of deliv	
	a death	Physician/M	in the past 12 months?  1 □ Yes 2 □ No	4 Pregnant at time of death	5 Other (specify)			Month	Day Year
P.0	that the de led by the a		9 ☐ Unknown  Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	og De	d by			, , ,		1 🗆 Yes	2 <b>₽</b> No 3 □ Pro	bably 4 Unknown
COL	law requir as been si 2 should	olete					24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re	The la	Completed					autopsy performe 1 Yes 2 i	ed2 death?	2 □ No
Vital Records,	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Hamital. 4	Oth		n (Check only one)	)	
of	Phys this al dir	To.	1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 Inpatient 2 ER/Ou  28a. Date of Injury 28b. T	tpatient 3 DOA Oth	4   Indising no	me 5 Residen 28d. Describe how	ce 6 Other (Spec	ify)
O	iding th. th. : After s funer	tlon	1 Natural 5 Pending 2 Accident investigation		njury Wor	k? Yes 2 □ No			
Division	Nor Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
Ö	Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the fune			!					
,	To the Hospital of within 24 hours at To the Funeral Completely filled it	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	/sicien: To the best of my knowledge iner: On the basis of examination and and manner stated.	<ul> <li>death occurred at the tir d/or investigation, in my o</li> </ul>	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	3 0 :	29c. Licens			d. Date signed (Month	. Dey, Year)
	- s - o		1 197	M.D.		P1767		02/04/0	,
	6		30. Name and address of person who o		(Type, Print) UNIV	ERSITY OF	= MARYLA	IND MEDIC	AL SYSTEMS
				32 Registrar's Signature	1.D. 29	S. GREEI	VE 57.	BALTIMOR	E, MD 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 0 20		Asserte)				

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 0014 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:55 AM JANUARY 160 2004 /Medical 4b. City, Toyon, or Location of Death 4c. County of Death Examiner HOSPICE AUTI MORE 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 214.38.4688 Days 100M 2□ F Director Usual Residence of Decedent 10d. Inside Ofty Limits 10b. County 10c. City, Town or Location ed other then "naturel", or Itama 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Itaneny injury or other traumatic access. 1 Never Married 2 Married LACK Baltimore, Maryland 21215-0036 1 Yes 2 No f Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CAB DALVER Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) TRANSPORTATION Flementary/See 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, MARYLAND ZIZI8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State N CEMETERY 1. 22.04 BATIMOLE, MARYLAND
22. Name and Address of Facility VANEHIN C. GREENE ENERGY HM - ZION CEMETER) \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee LORK ROAD BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequen **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 🗌 Yes 312No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural death. М 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D40854 2/6/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldinore 21202 SI. PAUL PL 301 Dand 1 Ciseber 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

LARRY R. JONES, JR. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 04 - 10541 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jr. R. Jones Larry FEBRUARY 6, 2004 2115 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5000 FREDERICK AVENUE N/ABALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Hours 1 €M 2 □ F 213-90-4566 26 Yrs. **Director** 8-29-77 Baltimore, Md Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23s or 28e-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director N/A Md. Baltimore (Windsor Mill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7408 Brivworth Ct. 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12marked other than College (1-4or 5+) Telecommuication  ${ t Metro}$ . 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernadette Fennell 2 R. Jones Larry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Fennell Mother 1202 E. Belvedere Ave, Baltimore, Md. 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Weetern Cem. 2-12-04 Baltimore, Md. 21. Signature of Funeral Service Licensee

Lloyd M. Estep

Estep Brothers Funeral
1300 Eutaw Place, Baltim
23a. Part1. Enter the I lease, or complications the caused the death. Shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
Estep Brothers Funeral Ser. P.A. 1300 Eutaw Place, Baltimore, Md. 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GUNSHOT HULTIPLE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se a consequence of the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 曹 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Ves 2 No 1 Ø es 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 □ No Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2/6/04 9:03 PM 1 ☐ Yes 2 No SHOT investigation SVBTECT WAS after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5000 Frederick Ave bathhore MD STREET within 24 hours a To the Funeral I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME FEBRUARY 7, 2004

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ANA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO, MD

& Sparks

111 Penn Street, Baltimore, Maryland 21201

f		30. Name and address of person wh Anil Chopra, MD			, Print)		4			10	11-00
complete	Medical	29b. Signature and title of certifier	ıminer: On the basis of examina and manner stated.	morr and/or in		License num			29d. Date sig		
Lo the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		4 Homicide determine  29a. Certifier 1 Certifying F	building, etc. (Specify	y) owledge, deat	th occurred	at the time, da	ite and place,	and due to the c	n, State) ause(s) and	manner as s	al Route Number,
ctor: After th	Certification: 7	27. Menny of Death  1. Autural 5 Pending investigate  2. Accident 6 Could not	he	28b. Time o Injury	М	8c. Injury at Work?	2 🗆 No	28d. Describe h			al David- Ale
this ce il direc	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2				☐ Nursing Ho	ome 5 D esid			fy)
ertific ictor,	Be	25. Was case referred to medical examiner?					Place of Deat	h (Check only or			
ate has ber page 2 sho	Completed							24a. Was a autops perfor 1 Yes	SV a	b. Were auto prior to co death? 1 \( \sum \section \text{Yes}	opsy findings avail impletion of cause 2 No
been signed should be det	by	Part II. Dther significant conditions	contributing to death but not rest	ulting in the u	inderlying ca	ause given in f	Part I.				he cause of death bably 4 Dunkn
by the ached	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1  Live birth 2 Fetel 4 Pregnant at time of di 9 Unknown	Idéath 3[	⊒Ectopic pro ☐ Other (spe					Date of deliv	Day Year
attending physician and for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of the consequ								
sician edical miner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequence)	(	erec	20	inga ialal	les	)		
# # Q	12 1	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death	Do not ent		e of dying, suc	ch as cardiac	or respiratory arr		MD 21	061 Approximate Interval Between Onset and Death
Important: if item any injury or othe once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signs ure of Funeral 3-rvi Lice	7					004 ngleton Glen Bu	Glen I Funera		
if item 27 or other to		Mrs. Hope Johns  20a. Method of Disposition  1 © Burial 2 □ Cremation 3 if  4 □ Donation 5 □ Other (Spec	20b. P	lace of Disno	sition (Nam			eb 10	20c. Locatio	n - City or T	
in in	Ĕ	19a. Informant's Name/Relationship						al Route Number		m, State, Zip 21060	Code)
	To Be Co	17. Father's Name (First, Middle, Las Jerome Johns	·				Mother's Nam Unkno	e (First, Middle, . WN			
	Completed	(Specify only highest gi	College (1-4or 5+)	(Give life.	kind of word DO NOT us Execu	rk done during se retired)	most of work	ing		tingho	
natural', or items 23a or 28a-f ehow idical Esaminer must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1/2 Yes 2 No If Yes, Give Year or Dates: 43 – 46	162 Dece	1 Yes 2	No Spe	ecify:		Specific Spe		ite
ms 23a c	Funeral Director	1302 Howard Road	12. Was Decedent Ever in U.	S. 13.	Was Deced	21060 lent of Hispani		ecify Yes or No- Rican, etc.)	14. R	JSA ace - Ameri	
r 28a-f e inotified	irector	MD Anne Ar	undel G	len Bu	rnie 10f. Zip			1	0g. Citizen o		1 □ Yes 💥 💢
how		10a. State 10b. County		, Town or Lo			······································				10d. Inside City Lin
uneral rector			%Пм 2□ F 79	Yrs.		Days Ho	urs Min.	8. Date of Birth (Month, Day) Aug 31,	1924	Coul	place (State or For htry) FL
		1302 Howard Road  5. Social Security Number 6.3	Sex 7. Age (In yrs. I	ast birthday)	If Under	Glen Bu	urnie nder 24 Hrs.	8. Date of Birth			rundel
Examin		4a. Facility Name (If not institution, gir	re street and number)			Town, or Loca			4c. Cour	nty of Death	
hysici: /Medic		Yulee	•••		Johns	S		Month Februar	y 6, 2	Year 2004	11:00 P
		1. Decedent's Name (First, Middle, La	st)					2. Date of Deal			3. Time of Dea

		•	For Amend Item 17 per	States 29, M3	Nand / Depa Cei	artment of Hartificate of L	ealth and l Death	Mental Hy	giene, Reg. No.(	2004	03704
	Obvojsk		1. Decedent's Name (First, Middle, Last)		100.3			2. Date of Dea	ath Qay	Year	3. Time of Death
•	Physicia Medic/		ISEATRICE	001	MUSON			her	3	2000	100
· ·	Examin			PITAL		13-10-11	MORE			County of Dea	
	uneral irector		214 24 302.	M STE	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da 7-1-	1920	9. Bi	rthplece (State or Foreign ountry) Md
and	1.	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
Maryl	f sho	ō	Md N/A		Baltimore	!					1√ Yes 2□No
the	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	ten of What C	ountry?
E VE	23a o	ai D	4207 Liberty Hei	ghts Aven	ue	21207	7		U	S A	
5-UU36 72 hours after death with the Maryland	Important: If the man was a manual part of the fraction of the man and the manual of t	Completed by Funeral	1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕱 N If Yes, Give	0	Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2∑ No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		Black, Wh	erican Indian, ite, etc. Black
	tural'	q pa	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occupa	ntion		16h Kir	nd of Business	
715 iin 72	n "na	plet	(Specify only highest grade	College (1-4or 5	(Give	kind of work done d DO NOT use retired,	uring most of wo	rking		ivate	
ZTZ d with	4 3 E	mo;	Elementary/Secondary (0-12) 8th grade	N/A		Omestic			Fi	Ivale	Trome
Maryland 21215-0036 ad 2 should be filed within 72 hours aff tith and Mental Hydiene.	d oth	Bec	17. Father's Name (First, Middle, Last)	_				me (First, Middle,		Sumame)	
Yaa ould t	atic	ဥ	Onarios comises	Charles Har				nn Bayno			
Mar 12 sh hand	7 Is m traum		19a. Informant's Name/Relationship (Ty) Katherine Wilson			ng Address <i>(Str</i> eet a L Parkwood				21217	Zip Code)
T and	thar 2	1 3	20a. Method of Disposition	2008	20b. Place of Dispo	sition (Name of		Date	20c. Loc	cation - City o	r Town, State
noi ages	y or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place orial Parl		2004	Ran	dal1st	own, Md
Baltimore, permit. Pages 1 a Department of Hea	Importar any inju		21. Signature of Funeral Service License	90		2. Name and Addres	s of Facility	March F7 sh Avenu		est Salto,	Md 21215
			23a. Part1. Enter the disease, er compli	cations that caused	the death. Do not ent	er the mode of dying	g, such as cardia	or respiratory ar	rest,		Approximate Interval Between
Phy	sician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause in each iir	NARY A	RTIFRY	1)156	ME			Onset and Death
/M	ledical		resulting in death)	Due to (or as	consequence of):	1	17170	77.0			1
Exa	aminer		Sequentially list conditions	).							
/ 7	sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
xecut	and al-tran	хап	that initiated events resulting in death) Last	Due to (or as	a consequence of):						-
8760, cate be executed	physicien and the burial-transit			,	,,						
	g phy: as the	edicai									
. Box 6	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome 1□Live birth		Ectopic pregnancy			2	3d. Date of de	
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at		Other (specify)				Month	Day Year
P at the	ed by the a detached i	Phy	9 Unknown			- d- b is - s	e is Dead	22a Did t	abassa w	na anatributa	to the cause of death?
Records, P	5 9	l by	Part II. Dther significant conditions con	7	, 1	A selts			/es 2[		Probably 4 Onknown
De la constant de la	been si should	etec						24a. Was			autopsy findings available
Vital Records, siclan: The law requires t	has le 2	Completed				<u>.                                    </u>		autop	rmed2	prior to death?	completion of cause of
	certificate ector, pag	မ Co	25. Was case referred to medical				26 Blace of De	1 ☐ Yes ath (Check only o	No	1 ☐ Ye	s 25 No
of Vita Physiclan:	is certific director,	OB	evaminer?	lospital:	nt 2 ER/Outpatier	nt 3□ DOA Othe	ar-	lome 5 ☐ Resid		□Other (Sp	ecify)
	# #	n: T	27. Manner of Death	28a. Date of Injui (Month, Day			at	28d. Describe I			
Vision Attending	or: After	atio	Accident 5 ☐ Pending investigation	(,, 23)	,u.,y		res 2□No				
Division For Attending	Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, farm, st :. (Specify)	reet, factory, office		28f. Location (S City or Tox		d Number or F	Rural Route Number,
Div Hospital or	aral D		400								
Hosp 24 ho	within 24 nous after dear	Medical	29a. Certifier Secretifying Physical Check only one)	sician: To the best oner: On the basis of and manner sta	of my knowledge, deat examination and/or in ited.	n occurred at the tim vestigation, in my or	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
To the	To the complet	Me	29b. Signature and title of certifier	mainton 516		29c. License	number		29d. Date	signed (Mor	nth, Day, Year)
) ⊢ ³	/		Joseph (	sto M	1	0.	42634		FE	73 3	2004
L	1		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print)			, _	- 1	
			-	574. M	3015	T PAUL	- PLA	LE BA	2711	MORE	MS 21201
12° (1)	Sta		31. Date filed (Month, Day, Year)	E.	ar's Signature						
1967	Regist	rar	EED 1 0 200	14 Reduce	S. A.	Bell.					

			1 - For State Registrar AMEND ITEM #18	State of Maryland /	Department of A. Gertificate o	Health and M	Mental Hygie	2001	03705
			1. Decedent's Hanne (1 mst, middle, Eust)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		SHYAND .				Januar	1 28 2004	832AM
	Examir	ner	4a. Fecility Name (If not institution, give to Sinai Huspit	street and number) al of BAITIME	4b. City, Town	or Location of Death	1	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex		birthday) If Under 1 Yea	r If Under 24 Hrs.		9. Birthpl	ece (State or Foreign
4.0	Funeral Director			IM 280F 5	Yrs. Months Day	s Hours Min.	DEC. 22	ear) Count	
5	pu k		Usual Residence of Decedent  10a. State 10b. County	10c City To	own or Location		,		d. Inside City Limits
Ze Ze	Marylar f show led at	lor	maylan 2/	2	BALHMERE				T⊠Yes 2 □ No
10	r 28s	irec	10e. Street and Number		10f. Zip Code	)	10g	Citizen of What Count	ry?
()	23a o	ral D	3305 GIEN A	UG	2	1215		USA	
-	tems	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent o	Hispanic Origin? (Spuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
∑ 336	irs aft	by F	1. ► Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ 1	o Specify:		Specify: 13/a	cle
4NA 5-0036	72 hours after death with the Maryland natural', or items 23s or 28s-f show ulcal Examiner must be natified at	Completed by	15. Decedent's Edu (Specify only highest grade	cation 16	Sa. Decedent's Usual Occ (Give kind of work dor	upation	king 16	o. Kind of Business/Ind	ustry
22	nithin ne. hen	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use reti	red)	, and		
S P	filed within Hygiene. other than ent, the We	CO	17. Father's Name (First, Middle, Last)		CINILD	18. Mother's Nam	ne (First, Middle, Mai	den Sumame)	
San	e d fa	To Be	HAROLD Jun	GS		Thuis	-	FLAVIA	LOPEZ
₹ any	2 should and Men Is marke sumatic	-	19a. Informant's Name/Relationship (Ty		9b. Mailing Address (Stre		/		Code)
5 °. ∑	s 1 and 2 f Health item 27 other tra	1			305 C/EN	ALE- BAI	HHORE /	ld 21215	
HADON D. Saltimore,	Se to I		20a. Method of Disposition  1 Burial 2 Cremation 3 R	lemoval from State	of Disposition (Name of tery, crematory or other p	lace)	14/04	C. Location - City or Tov	vn, State
E S	permit Page Department Important: If any in ury o	b i	*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Liberse		o Ridge (	tress of Facility C.U.	ATMAX-1	TARKO HAR	int lane-
F. 7 Ba	Depar Impor any ir		Heronother	3	5248 K	Many/by	LUMO 5	-	
			23a. Part 1. Enter the disease, or complishoot, or heart failure. List only or	ications that caused the death. D					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARDIOPU	LMONAR	Y AR	REST		Onset and Death
<b>—</b>	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
9.	<b>建多多产</b>	e	Sequentially list conditions, if any, leading to immediate	BRAIN Due to (or as a sunsequent		Š			
IN	outed od ransit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
0,	sicien and burial-transit		resulting in death) Last	Due to (or as a consequence	e of):				
Box 68760	physic physic the b	dical		1.				-	
9 X G	eath certific attending p for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy				23d. Date of deliver	v
B	death e atter	Physician/Med	in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death	th 3 □Ectopic pregnar 5 □ Other (specify)				Day Year
P.O.	at the de I by the a stached	Phys	9 🗆 Unknown	9□ Unknown	****				
	ires tha signed to det	by	Part II. Other significant conditions cor	ntributing to death but not resulting	in the underlying cause	given in Part I.		co use contribute to the	
orc	w requir been si should	Completed							
Rec	The lay	dmo					24a. Was an autopsy performed	death?	sy findings available inpletion of cause of
tal	sician: Th certificate rector. pag	Be Co	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 € th (Check only one)	No 1 ☐ Yes	2 PNo
<u>&gt;</u>	nysici	ToB	examiner?	lospital: 1   Inpatient 2   PER/	Outpatient 3 DOA	1th as:		e 6 ☐Other (Specify,	)
0 0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	. Time of 28c. In Injury W		28d. Describe how	injury occurred	
Division of Vital Records,	utendi death. ctor: A y the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,		□Yes 2□No	28f Location (Street	t and Number or Rural	Poute Number
Div	spital or Attours after dones after dones after dones lilled in by filled in by fil	Certification:	4 Homicide determined	building, etc. (Specify)	rami, street, ractory, ome	9	City or Town, S		TIODIO INDICIDOR,
	lospita hours unera ily fille		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled ner: On the basis of examination	lge, death occurred at the	time, date and place	, and due to the caus	e(s) and manner as sta	ited.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	and manner stated.		nse number			
	T will		29b. Signature and title of certifier	NWOKORIE				Date signed (Month, E	
	1		30. Name and address of person who co	impleted cause of death (Item 23a	a) (Type, Print)	0110		BN 3	1216
	V		DR. NDIDI NWOKE	RIE, 2401	WEST BEL	NEDERE	AUE,	BALT., Z	1619
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 Small !				

amend 7,8, per F.H. g831 5/6/04 KB
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici	20	Decedent's Name (First, Middle, L.	ast)		2. Date of Death Month	ay Yeer	3. Time of Death
/Media		Tyquan	Quan	Jackson		05, 2004	2:31 A
Examir	ner	4a. Fecility Name (If not institution, g		4b. City, Town, or Location of Dea	ath 4	lc. County of Deeth	i e
		University of Ma 5. Social Security Number 6.	ry.Land Medical ( Sex 7. Age (In yrs. Ia	st hirthday) If Under 1 Year If Under 24 Hr	s. 8. Date of Birth 20 n. (Month, Day, Yea	N/A 9. Birth	place (State or Forei
uneral irector		212-69-1793	1 <b>X</b> M 2□ F	Yrs. Months Days 16 Hours Min	n. (Month, Day, Yea	03 00	intry) 1D
2.00		Usual Residence of Decedent	100 City				10d Jacido City Limit
ehow id at	7	10a. State 10b. County	Toc. City	, Town or Location			10d. Inside City Limi 1
n or ream and weather ryyener.  If item 27 is marked other then "natural", or items 23a or 28a-1 ehos or other traumatic event, the Medical Examinar must be notified at	Director	MD NA  10e, Street and Number	Ba	ltimore 10f. Zip Code	100	Citizen of What Cou	
No or				21217		U.S.A.	, .
ms 2	Funeral	741 Lennox St; 11. Marital Status	12. Was Decedent Ever in U.S			14. Race - Amer	
or le	Ē	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 No Specify:	arto Alcan, etc.)	Black, White	, etc.
ural'.	d by	3 Widowed 4 Divorced	Year or Dates:			В.	lack
"nati	Completed	15. Decedent's (Specify only highest		16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b.	Kind of Business/Ir	ndustry
then	m C	Elementary/Secondary (0-12) N/A	College (1-4or 5+) N/A	N/A		N/A	
marked other then " umatic event, the Mar	BeC	17. Father's Name (First, Middle, La			ame (First, Middle, Maid	en Sumame)	
rked Sign	To B	John Jackson		Quarno	da Seller	s	
ls ma		19a, Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number or I			ip Code)
item 27 l		Quarnoda Sell		741 Lennox Street			21217
r of		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Domoval from State	ace of Disposition (Name of imetery, crematory or other place)		Location - City or T	
tant		`4 □Donation 5 □ Other (Spe	cify) Kin	g Memorial Park 2/	11/04 Ra	ndallst	own, Ma
Department of repartment of repartments if ite any injury or of once.	li l	21. Signature of Funeral Service Lie	eetane	March F H West 4300 Wabash Ave	Paltimo	ro Md :	21215
19.0		23a Part Enter the disease, or co	omolications that caused the death	. Do not enter the mode of dying, such as cardi		Le na .	Approximate
		show, or heart wure. List or Immediate Cause (Final					Interval Between Onset and Death
ysician Iedical		disease or condition resulting in death)	a. Sudden Unexp  Due to (or as a consequ	lained Death in Infanc	CA (20DT)		
aminer				ence or).			
4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (b) as a consequ	alica olf).			
ransi	aml	that initiated events	c				
hysician and the burial-transit	Ical Examiner	resulting in death) Last	Due to (or as a consequ	ence of):			
S			d				
the	60		23c. If yes, outcome of pregnal	ncv		004 0-4-4-1	
ding physe	×	IF FEMALE:				23d. Date of delin	Day Year
ding b	lan/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetel			1	
ding b	ysiclan/Me	23b. Was decedent pregnant	1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown				
y the attending pached for use as	y Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown		23e. Did tobacc	o use contribute to	the cause of death
y the attending pached for use as	ed by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	4□Pregnant at time of de 9□Unknown	eath 5 Other (specify)		o use contribute to	L
been signed by the attending p should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	4 ☐ Pregnant at time of de 9 ☐ Unknown s contributing to death but not resu	eath 5 Other (specify)	1 ☐ Yes 24a. Was an	2 No 3 Pro	obably 4 DÜnkno
has been signed by the attending p je 2 should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	4 ☐ Pregnant at time of de 9 ☐ Unknown s contributing to death but not resu	eath 5 Other (specify)	1 ☐ Yes  24a. Was an autopsy performed	2 No 3 Pro	topsy findings available ompletion of cause
ate has been signed by the attending p page 2 should be detached for use as	e Completed	23b. Was decedent pregnant in the past 12 months?  1	4 ☐ Pregnant at time of de 9 ☐ Unknown s contributing to death but not resu	eath 5 □ Other (specify)	1 ☐ Yes	2 No 3 Pro	obably 4 Dunkno
certificate has been signed by the attending p ector, page 2 should be detached for use as:	Be Completed	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant condition  Complications	4 Pregnant at time of de 9 Unknown	eath 5 □ Other (specify)	24a. Was an autopsy performed 1 Yes 2 □	2 No 3 Pro 24b. Were authorior to codeath? No 140 Yes	obably 4 Dunknotopsy findings available ompletion of cause 2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	4 Pregnant at time of de 9 Unknown  s contributing to death but not results of Prematurity  Hospital: 1 Unpatient 2	26. Place of DER/Outpatient 3 DOA Other: 4 Nursing 28b. Time of 28c. Injury at	24a. Was an autopsy performed 12 Yes 2 Uneath (Check only one) 14 Home 5 Residence 28d. Describe how in	2 No 3 Pro 24b. Were aut prior to c death? No 1 Yes 6 Other (Spec	obably 4 Dunknotopsy findings available ompletion of cause 2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1   Inpatient 2   1   28a. Date of Injury (Month, Day Year)	26. Place of D  ER/Outpatient 3 DOA  28b. Time of Work?  To initial M  1 Yes 2 M No	24a. Was an autopsy performed 12 Yes 2 Urgent (Check only one) 19 Home 5 Residence 28d. Describe how in Unknown	2 No 3 Pro 24b. Were aut prior to c death? No 1 Yes 6 Other (Specially)	obably 4 DUnknotopsy findings availad ompletion of cause 2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1   Inpatient 2   1   28a. Date of Injury (Month, Day Year)	26. Place of D  ER/Outpatient 3 DOA  28b. Time of 28c. Injury at Work?  1 Ves 2 No.	24a. Was an autopsy performed 12 Yes 2 □  leath (Check only one)  Home 5 □ Residence 28d. Describe how in Unknown  28f. Location (Street City or Town, St	2 No 3 Pro  24b. Were aut prior to c death? No 14 Yes  6 Other (Specially) and Pager 2 Security	obably 4 DUnknotopsy findings availad ompletion of cause 2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpatient 2 Hospital: 1 Inpatient 2 Hospital: 1 Canada Premia Premi	26. Place of DER/Outpatient 3 DOA Other: 4 Nursing 28b. Time of Chief Work?  1 46 a M 1 Yes 2 No me, farm, street, factory, office	24a. Was an autopsy performed 12 Yes 2 Under 12 Check only one) 14 Home 5 Residence 28d. Describe how in Unknown 28f. Location (Street City or Town, St. Baltimore	2 No 3 Pro 24b. Were aut prior to c death? No 14 Yes  6 Other (Specially) and Norther of Bu are)	topsy findings availation of cause  2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  1   Inpatient   2   28a. Date of Injury (Month, Day Year)   28b. Place of Injury - At he building, etc. (Specify Found in resemblers)  Physicien: To the basts of examinar: On the basts of examinar:	26. Place of DEP/Outpatient 3 DOA  28b. Time of Work?  1 Yes 2 No  me, farm, street, factory, office	24a. Was an autopsy performed 1 Yes 2 Uneath (Check only one) Home 5 Residence 28d. Describe how in Unknown 28f. Location (Street City or Town, St. Baltimore.	2 No 3 Pro 24b. Were aut prior to c death? No 14 Yes  6 Other (Specially) and Norther of Bu are) ND  (s) and manner as	lopsy findings availade ompletion of cause 2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1   Inpatient 2    28a. Date of Injury - At he bed by Programment to the ed    28b. Place of Injury - At he building, etc. (Specify Found in res	26. Place of D  27. Place of D  28. Injury at Work?  1.46 a	24a. Was an autopsy performed 12 Yes 2 Uneath (Check only one) 19 Home 5 Residence 28d. Describe how in Unknown 28f. Location (Street City or Town, St. Baltimore 19 Notes, and due to the cause coursed at the time, date	2 No 3 Pro 24b. Were aut prior to c death? No 14 Yes  6 Other (Specially) and Norther of Bu are) ND  (s) and manner as	topsy findings available ompletion of cause 2 No
certificate has been signed by the attending p ector, page 2 should be detached for use as:	edical Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  1   Inpatient   2   28a. Date of Injury (Month, Day Year)   28b. Place of Injury - At he building, etc. (Specify Found in resemblers)  Physicien: To the basts of examinar: On the basts of examinar:	26. Place of D  26. Place of D  27. Other: 4 \( \) Nursing  28b. Time of 28c. Injury at Work?  1 \( \) Yes 2 \( \) No  28 death occurred at the time, date and plation and/or investigation, in my opinion, death occurred at the time.	24a. Was an autopsy performed 12 Yes 2 Death (Check only one) 12 Home 5 Death (Check only one) 28d. Describe how in Unknown 28f. Location (Street City or Town, St. Baltinore, and due to the cause coursed at the time, date 29d.	2 No 3 Pro 24b. Were aut prior to c death? No 14 Yes  6 Other (Specially) and Nother aut prior to c death? 14 Yes  6 Other (Specially) and Nother aut prior 15 years and place, and due Date signed (Month	topsy findings available ompletion of cause 2 No
or this certificate has been signed by the attending peral director, page 2 should be detached for use as:	edical Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	Hospital:    Hospital:   Inpatient   2   28a. Date of Injury (Month, Day Year)   28e. Place of Injury - At he building, etc. (Specify Found in resembler: On the basis of examinar and manner stated.	26. Place of D  26. Place of D  27. Other: 4 \( \) Nursing  28. Time of 28c. Injury at Work?  1 \( \) Yes 2 \( \) No  29c. License number  29c. License number  0 \( \) C \( \) M	24a. Was an autopsy performed 12 Yes 2 Death (Check only one) 12 Home 5 Death (Check only one) 28d. Describe how in Unknown 28f. Location (Street City or Town, St. Baltinore, and due to the cause coursed at the time, date 29d.	2 No 3 Pro 24b. Were aut prior to c death? 1 Yes 6 Other (Specially) 1 A Yes  6 Other (Specially) 1 A Yes  1 A	topsy findings available ompletion of cause 2 No

		1	For AMEND ITEM # State Registrar AMEND ITEM #17	25 FER PHY 6829 3	d / Departmen 0/16/04 Gentifica	nt of Health and I te of Death	Mental Hyg	giene Reg. No. 20	04 03707
	Physicia		1. Decedent's Name (First, Middle, Last	nes		-	2. Date of Dea	201	3. Time of Death
	/Medic	al .	4e. Fecility Neme (If not institution, give		4b. City	, Town, or Location of Death		4c. County of	of Death
				Maryland He		activare or 1 Year   If Under 24 Hrs.	8 Date of Birt	Batti	9. Birthplace (State of Foreign
	Funeral Director		5. Social Security Number 6. Se 2/8 - 16 - 77.76	X 7. Age (In yrs.	Yrs. Months		8. Date of Birt (Month, Day	y, Year) 2 2	MARYLand
	D.		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Maryla -f ehor	tor	MARYLAND		Battem	re cit	1		1 Nes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, I'm Medical Examinal montal to motified at ODGE.	Director	10e. Street and Number	Ave.	10f. Z	p Code		10g. Citizen of W	/hat Country?
	death v	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Deci	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puerl	pecify Yes or No	- 14. Race	e - American Indian, k, White, etc.
36	rs atter i', or ite	by Fu	1 Never Married 2 Married 3 Nowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		2 No Specify:		Specify:	Piccis
5-0036	72 houn		15. Decedent's Ed (Specify only highest gra	ucation	16a. Decedent's Us	ork done during most of wo	rking	16b. Kind of Bu	siness/Industry .
2121	within lene.	Completed	Elementary/Secondary (0.12)	College (1-4or 5+)	life. DO NOT	use retired)		Food	Service
	be filed stat Hygie of other	Be Co	17. Father's Name (First, Middle, Last)	1 - 5	iones	18. Mother's Nar	ne (First, Middle,	Maiden Sumame	e)
Maryland	should be and Mental marked o	ို	19a. Informant's Name/Relationship (			ss (Street and Number or Ri	ural Route Number	er, City or bown,	State, Zin Code)
	1 and 2 sho Health and Iem 27 is ma		Larve Dou	5 (Neice)	3913 8	Shannon	10	ve E	xitto, Md.
Baltimore,	Pages 1 and of He Int: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition (Na cometery, crematory or	other place	Date 31/04	20c. Location -	City or Town, State
altin	permit. Pag Department Important: I eny injury o		* 4 □ Donation 5 □ Other (Specify 21. Signature Foneral Service Lice		22. Name a	and Address y Facility	1 0	1639 N.	Occadway
B	Depar Impo eny ir		my hay to	etter	Miller	s Thethefold	lan Ch	apel	Balto. Md.
			23a Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	/		c or respiratory a	mest,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (o as e consec		ardion			
Ř	Examiner	-	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	b. Due to for as a consec	quence of):				
0.	cuted nd ransit	Examiner	that initiated events	· menn	mla				
760,	es that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit	cai Ex	resulting in death) Last	Die to (or as a consec	quence of):				
68	ifficate g phys			. d					
Box	ath cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Feta	al death 3 Ectopic			23d. Date Mor	e of delivery nth Day Year
P.O. I	the de by the a ached f	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5 Other (	specny)			B0 111
	w requires that the death certifica been signed by the attending ph should be detached for use as th	Completed by Pl	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	1		ribute to the cause of death?  3 Probably 4 Unknown
Vital Records,	aw 2 sl	npiet					24a. Was	psv p	Were autopsy findings available prior to completion of cause of death?
tal F	ate pa		25. Was case referred to medical			26. Place of De	1 ☐ Yes	2 No 1	Yes ZENo
of Vi	S D	To Be	examiner?	Hospital: Inpatient 2	ER/Outpatient 3 [	OCA Other: 4 Nursing	Home 5 Resi	dence 6 Othe	
o uo	fter fter		27. Manner of Death  XX Natural  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurr	ed
Division	f or Attending after death, Director: Afte in by the fune	Certification:	2 Accident / Investigation 3 Suicide 6 Could not b 4 Homicide determined		nome, farm, street, factorify)	ory, office		Street and Numb wn, State)	er or Rural Route Number,
/	To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier Certifying Ph (Check only 2 Medical Exar	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and plac on, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier			9c. License number			(Month, Day, Year)
			1 sepun to		) · D .	P 14653	-10		26/04
	3		30. Name and address of person who	completed cause of death (Ite 1 artin, M.	m 23a) (Type, Print) D. 22 S-	Greene St.	Balti	more,	MD 21201
	St Regist	ate	31 Date filed (Month, Day, Year)  FER 1 0 2004	32. Registrar's Sign	ature	-			

					Maryland / Depa			-	•	
			1 - For State Registrar	3.4.3 3.		rtificate of I		_	No. 2001	03708
	Dhuaisi		1. Decedent's Name (First, Mic	ldle, Last)				2. Date of Death Month	day Year	3. Time of Death
	Physici /Medi		HEBBER"	r.G KN	SIGHT			2/4	104	3:06pm
*	Examir	ner	4a. Facility Name (If not institut	ion, give street and numb		4b. City, Town, or	Location of Death		4c. County of Dea	th
	Funeral		5. Social Security Number		Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birt	thplace (State or Foreign
	Director	1	12-22-4561	<b>№</b> M 2□ F	75 Yrs.	Months Days	Hours Min.	(Month, Day, Y	78 Not	The Cardina
	and w		Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. City, Town or Lo	ocation		1 ' 1		10d. Inside City Limits
	Maryl -f sho	ţō	MD		Palt	more	,			1 ⊈es 2 No
	th the or 28a s.rotti	lrec	10e. Street and Number		00111	10f. Zip Code		10g	. Citizen of What Co	ountry?
	ath wi	ral	800 Beau	mont Au	enue	99	12	(	ISA	
	ter de itema	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ M	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	crfy Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	encan Indian, e, etc.
99	urs af	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	es:	1 ☐ Yes 2 Do	Specify:		Specify R	ack
215-0036	within 72 hours after death with the Maryland one. then "natural", or items 23s or 28s-1 show the Medical Examinat must be notified at	Completed	15. Deced (Specify only high	ent's Education hest grade completed)	(Give	dent's Usual Occupa	during most of worki	ng 16	b. Kind of Business	Industry
121	within iene. then	dmo	Elementary/Secondary (0-12	College (1-4	life.	DO NOT use retired	+	1-	AIDIS	trial,
d 21	Hygie other		17. Father's Name (First, Middle	le, Last)	190	1 PMEN	18. Momer's Name	(First, Middle, Mai	den Sumame)	SVI 75-C
<u>lan</u>	iould be i Mental varked o	To Be	Georgo, K	wight			Mari	Heus	lin	
Maryland	2 she and and ls m		19a. Informant's ame/Relatio	nshi ype, Print)	19b. Mailin	ng Address (Street a	and Number or A ra	l Route Number, C	ity or Town, State, 2	Zip Code)
	1 and Health em 27 ither tr		20a. Method of Disposition	ht (Wite	20b. Place of Dispo	Beaun	cont Au		MDA	12/2
Baltimore,	Pages net of F int: If ite		1 Burial 2 ☐ Crematio	n 3 □Removal from Sta	cometant cree	matory or other plac		200	c. Location - City or	I own, State
altin	permit. Pag Department Important: I any injury o		*4 Donation 5 Other  21. Signature of Funeral Service		- GOTTSON	Name and A	Medical of	9/04/1	lings Mil	15, 191
ñ	permit. Departr Imports any inje		) Va	In Grune	_	Jangh N (	Joek o	18. THY	to MD	SID I A
	1 1		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that caused ist only one cause on each	sed the death. Do not ent h line.	er the mode of dyn	g, such as cardiac o	r respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- a Moto	static N	SCLC	A			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					<del></del>
	p.	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence or):					
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1						
0,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or	as a consequence of):					
09289	2 > 9	dical		d						
9 x c	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy				23d. Date of del	aran.
Box	death atter d for L	iclar	in the past 12 months?	1□Live birth 4□Pregnan	n 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
P.0	at the by the	hys	9 🗆 Unknown	9□ Unknow						
	res tha igned be de	Ď	Part II. Other significant cond.	tions contributing to deat	h but not resulting in the u	nderlying cause give	en in Part I.	T .		the cause of death?
ord	requi	eted						1 Tes		
Records,	ne law has b ge 2 s	Completed						24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
Vital	in: The	မ လ	25. Was case referred to media	cal			26. Place of Death	1 □ Yes 2	No 1 ☐ Yes	21X No
fVi	d is	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 ER/Outpatien	at 3 DOA Othe		0 to 1 to 1 to 1 to 1 to 1	e 6 □Other (Spec	city) Haracases
n of	ding Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of I (Month,	njury 28b. Time of Injury	Work	at 2	8d. Describe how		
Division	Attending or death.	cat		stigation	Jaimer Albana famous		Yes 2 □ No	104		100
Div	after Direction by	Certification:	4 Homicide dete	mined 286. Place of building,	Injury - At home, farm, str , etc. (Specify)	eet, factory, office	-	City or Town, S	t and Number or Ru tate)	rai Houle Number,
	ospite hours uneral y filled	alc	29a. Certifier 12 Certif	ring Physicien: To the be	est of my knowledge, death	occurred at the tim	ne, date and place, a	and due to the caus	e(s) and manner as	stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	Une)	and manner	s of examination and/or in stated.	vestigation, in my op	oinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certification	ier	ALF	29c. License	number	29d.	Date signed (Month	n, Day, Year)
	10		20 Name and add	* COSTUDE	30 KID	- KIA	417403E	Q 1-5 PC	Ebruaryi	06, 2004
	U		30. Name and address of person	PICALLO- #	STINDZE	+ Cyan	nolonia	Comonic	EMON E	and appointed
	Sta		31. Date filed (Month, Day, Yea		istrar's Signature	1 O GEX	" Estable	ONDA	Filler F	TRAINE TO THE
	Registr	ar	FEB 10	2004 Freday	w to App	de!				
DH	MH 17 Rev 1/2	001		357						

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day H 2004 Teresa Klein - Ebryen Principe 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Armodel Burnal V52 (5)m Anna Armod If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2\ F 83 151-10-5097 May 28, 1920 NΥ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Glen Burnie Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1134 Wynbrook Road 21060 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1□ Yes 2□ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0il Company Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Principe John Marie Choida 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Kathleen Klein / Daughter 5385 Broadwater Lane Clarksville, MD 21029-1119 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 7 4 Donation 5 Dether (Specify) Glen Haven Memorial Park Glen Burnie, MD 2004 21. Signature of Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? T Yes ZIXNO 1 ☐ Yes 2 🗖 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner P.O. Box 68760. of Vital Records, Division

physician a for use es signed by the a page 2 should peen

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

**Funeral** 

Director

Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show

altimore, Maryland 21215-0020

if Health and Mantel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f sho other traumstic event, the Medical Examiner must be notitled at

Department of H important: If ite any injury or of once.

ours effer death.

•rai Director: After this certificete has tifiled in by the funeral director, page 2 s Physician: or A To the Hospital
within 24 hours a
To the Funeral C Physician/Medical Examiner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed 25. Was case referred to medical examiner? Certification: To Be 1 Yes 2 No 27. Manner of Death Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

BUA 31. Date filed (Month, Day, Year) State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DOF

1001

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death **Physician** WARY 9, 2004 /Medical 4b. City, Town, or Locetion of Death 4c. County of Death Examiner 7. Age (In yrs If Under 1 Year Birthplace (State or Foreign Country) Jast birthday) Funeral Months Days Hours 1 □ M 2 KE Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits injury or other traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 📉 No **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21286 USA 11 Marital States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced Blad Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed withir Depertment of Health end Mental Hygiene. Important: if item 27 is markad other than Elementary/Secondary (0-12) ector creation Center 1EUS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) homas Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. To not enter the mode of dying Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner or Attanding Physician: The law requires that the death certificeta ba executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No disense 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Tyes 2FTNo 3 DOA eral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 412004 140854 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

FEB

1 0 2004

Dallimore

301

32. Registrar's Signature

		1 - For State Registrar Amend Item#20bp	State of Maryland / Deporting 28 2/10/04 EW Ce		Mental Hygier	- 2110L 03719
Physi		Decedent's Name (First, Middle, Last)     Franklin		Lassiter Jr.	2. Date of Death Month Februar:	Day Yeer 3. Time of Death 2. 2004 834 D M
Exam		4a. Fecility Name (If not institution, give s  Maryland G-Er  5. Sociel Sepurity Number 6. Sex	eral Hospital	4b. City, Town, or Location of Dea Pactimore	th	4c. County of Deeth
Funera Directo	A. S	219-28-1615 X	M 2□F 71 Yrs.	Months Days Hours Min		32 NC
Maryland -1 show	tor	Usual Residence of Decedent  10a. State 10b. County  MD NA	10c. City, Town or L			10d. Inside City Limits 1
or 28a	Director	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?
17215-0035 within 72 hours after death with the Maryland ene. than "naturat", or items 23s or 28s-f show he Modical Examiner must be notitied at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No	21207 Was Decedent of Hispanic Origin? (§	Specify Yes or No- to Rican, etc.)	U • S • A •  14. Rece - American Indian, Black, White, etc.
21215-0036 d within 72 hours af giene. or then "naturat", or	ted by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	Year or Dates:	1 ☐ Yes ② No Specify:  dent's Usual Occupation skind of work done during most of wo	16b.	Specify: Black Kind of Business/Industry
STZTZ I I I I I I I I I I I I I I I I I I	Completed	Elementary/Secondary (0-12)  12th grade  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	nck Driver		acking Company
Maryland d 2 should be file th and Mental Hy 77 is marked othe traumatic event,	To Be	Franklin Lassi 19a. Informant's Name/Relationship (Ty)		Ida Wa	fers	,
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exeminer must be notified at	-	Tracy Lassiter-( 20a. Method of Disposition  1♥ Burial 2 □ Cremation 3 □ R  4□ Donation 5 □ Other (Specify)	20b. Place of Disposition State ST Thomas (	osition (Name of matory or other place) Cemetery 2/7,	Date 20c.	nore Md 21207  Location - City or Town, Stete
Dermit. Departminimporte	83000	21. Sure ture of Fineral Scrope license  23a. Part I. Enter the disease, or compli	( ) 2 N	2 Name and Address of Facility larch F/H West 300 Wabash Ave	e Baltimo	
Cale be executed  Examine by Sicion and by Sicion and by Sicion and by Sicion and the burial-transit	al 📄	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  The to (or as a consequence of):  Due to (or as a consequence of):	1 Hemorrhag	ge.	Onset and Death
I RECORGS, P.O. BOX of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
COLDS, P. w requires that been signed b	D S	Part II. Other significant conditions cor	tributing to death but not resulting in the u	underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
DIVISION OF VITAL HECOFGS, to a Attending Physician: The law requires the death.  Director: After this certificate has been signe tin by the funeral director, page 2 should be of the bythe funeral director, page 2 should be of the funeral director.	Completed				24a. Was an autopsy performed 1 Yes 2 2	
r Vital P ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient 2 ER/Outpatie	Other	ath (Check only one) Home 5 ☐ Residence	6 □Other (Specify)
SION OF VITAL He anding Physician: The sath.  or: After this certificate his he funeral director, page	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	of 28c. Injury at Work?  M 1   Yes 2   No	28d. Describe how in	jury occurred
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Ste	
To the Hospitat within 24 hours a To the Funeral C completely filled	edicai	29a. Certifier 1 Certifying Physics (Check only one) 1 Certifying Physics 2 Medical Examination	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in end manner stated.	th occurred at the time, date and place overstigation, in my opinion, death occurred.	e, and due to the cause urred at the time, date a	(s) end manner as steted.  Ind place, and due to the cause(s)
To t Withi Comp	×	29b. Signature and title of certifier	2 MD	29c. License number 89509	29d. (	Date signed (Month, Dey, Year)  2/2/04
7		Syed Raza	mpleted cause of death (Item 23a) (Type	Print) Gener	ral Hos	spital
Regi	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	K. Could ?		

	For State Registrar	State of Maryland /	Certificate of		Re	g. No. 2004	03713
V v	1. Decedent's Name (First, Middle, Last)				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
Physician /Medical -	ROBERT JAN	ES LAIRD			Februar	y 6, 2004	11:30 P.™
	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	or Location of Death		4c. County of Death	
	Gilchrist Center		Tows			Baltimo	
ineral rector	5. Social Security Number 6. Sex 214–26–8272	7. Age (In yrs. last.	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 19	, 1928 Mai	place (State or Foreign intry) Cyland
) H	Usual Residence of Decedent  10a, State 10b, County	10c City To	own or Location				10d. Inside City Limits
If item 27 is marked other than "natural", or Items 23s or 28e-f show or other traumatic event, the Modeal Examiner must be nutlised at To Be Completed by Funeral Director							1 ☐ Yes 2 ☒ No
be natified	Maryland Baltimo	re 1	OWSON 10f. Zip Code		10	Og. Citizen of What Cou	into/2
	520 Yarmouth Road			21286		U.S.A.	
Funeral		12. Was Decedent Ever in U.S.			cify Yes or No-	14. Race - Amer	
F.	1 Never Married 2 Married	Armed Forces?	13. Was Decedent of H If Yes, specify Cub	an, Mexican, Puerto F	Rican, etc.)	Black, White	
by	3 Widowed 4 Divorced	1 XYes 2 ⊡ No If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🖁 No	Specify:		Specify: W	hite
Completed	15. Decedent's Edu	cation 16	6a. Decedent's Usual Occup (Give kind of work done	pation	1	16b. Kind of Business/li	ndustry
ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	d)	,9		
5		4 years (	Chief Deputy	1		State Lott	ery
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	faiden Sumame)	
2	Frank Leslie La	ird				Ierzog	
117	19a. Informant's Name/Relationship (Ty)		9b. Mailing Address (Street				
	Lillian L. Laird		20 Yarmouth		The second secon	yland 2128	
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R		e of Disposition (Name of otery, crematory or other pla			20c. Location - City or T	own, State
	*4 □ Donation 5 □ Other (Specify)	Green	n Mount Crema	tory 2-9-0	)4 B	Baltimore,	Maryland _
SDCS.	21. Signature of Funeral Service License	98 UN	Mitchell-	ess of Facility Wiedefeld Maryland	Funeral	Home, Inc	• 6500 York Rd
	23a, Part1, Enter the disease, or compli	cations that caused the death. D	o not enter the mode of dying	ng, such as cardiac o	r respiratory arre	est,	Approximate
(0.1	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	CAALC	2.0			Interval Between Onset and Death
an al	disease or condition resulting in death)	Die to (or as a consequent	C GANC				pe-ve-3
ner		7,				]	
e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):				
Examine	Cause (Disease or injury that initiated events					4	
Exa	resulting in death) Last	Due to (or as a consequent	ce of):				
cal Examin	L,	1					
Ved	1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m						
Physician/Medic	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3⊡Ectopic pregnanc	y		23d. Date of delin	very Day Year
y Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐ Unknown	5 ☐ Other (specify) _			Month	Day 16a1
P. Y	9 🗆 Unknown			e en	OO- Didash		the course of death?
2	Part II. Dther significant conditions con	itributing to death but not resultin	g in the underlying cause given	ven in Part I.		acco use contribute to	
Completed					1 ☐ Ye		
ple					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
6					perform 1 ☐ Yes 2		2□ No
	25. Was case referred to medical examiner?			26. Place of Death	(Check only one	9)	
BeC		lospital: 1 Inpatient 2 EPV	Outpatient 3 DOA	her: 4 ☐ Nursing Hon			in hospice
To Be C	1 ☐ Yes 2 No	28a. Date of Injury (Month, Day Year)	b. Time of 28c. Inju Wo		8d. Describe ho	w injury occurred	
To Be	1 Yes 2 No	(Month, Day rear)	M 1	Yes 2 □No			
cation: To Be C	1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation					reet and Number or Ru	ral Route Number,
rtiflcation: To Be C	1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending	28e. Place of Injury - At home building, etc. (Specify)		2	28f. Location (Str. City or Town,		
Certification: To Be C	1 Yes 2 No Fig. 1 Yes 2 No Fig. 1 Yes 2 No Fig. 2 No Fig	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office		City or Town	. State)	etotad
dical Certification: To Be C	27. Manner of Death 1. Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifier (Cock by 2   Medical Exami	28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowleder: On the basis of examination	, farm, street, factory, office	me, date and place, a	City or Town,	. State) use(s) and manner as	
To Be	1 Yes 2No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	dge, death occurred at the transformation investigation, in my of the control of	me, date and place, a opinion, death occurre	City or Town, and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	to the cause(s)
Medical Certification; To Be C	1   Yes   Ye	28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowleder: On the basis of examination	dge, death occurred at the transformation investigation, in my of the control of	me, date and place, a opinion, death occurre	City or Town, and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	to the cause(s)
completely filled in by the funeral director, or Medical Certification; To Be C	1   Yes   2   No   F  27. Manner of Death 1   Natural 2   Accident 3   Suicide 4   Homicide   6   Could not be determined    29a. Certifier (C x y y 2   Medical Examination   29b. Fign. ure in little of certifier	28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowlener: On the basis of examination and manner stated.	dge, death occurred at the transformation investigation, in my of the control of	me, date and place, a opinion, death occurre	City or Town, and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	to the cause(s)
potential of the fundral director.  edical Certification; To Be	1   Yes   Ye	28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowlener: On the basis of examination and manner stated.	dge, death occurred at the till and/or investigation, in my death occurred at the till and/or investigation, in my death occurred at the till and/or investigation, in my death occurred at the till and occurred at the till	me, date and place, a opinion, death occurre	City or Town, and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:00 P.M February John Charles Lukaszczyk 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4120 Duane Avenue Apt. 1 Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F Yrs 191 18 9605 80 May 8, Director Pennsylvania Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, I're Medical Examinar roust be notified at 11 Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4120 Duane Avenue Apt. 1 21225 U.S. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 K⊉Yes 2 □ No If Yes, Give ↓ Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Š WW II 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene. ant: If item 27 Is marked other than Truck Driver 8th Anne Arundel County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Lukaszczyk Kunedunda Shuba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Lukaszczyk / wife 4120 Duane Avenue Apt. 1 Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) MD State Veteran Cem. 2/9/2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 much ramervil. 23a. Part1. Enter the diseas and implications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Year Day 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 2 **□**No 1 Tes 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 12 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification; . After To the Hospital or Attending 5 Pending investigation death. 2 🗆 No 2 Accident rector: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 6 address of person who comp 23a) (Type, Print) MARIO J. REDA MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 4:30A<sup>M</sup> 1 2004 Mary Rose Mazza /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll County General Hospital Carrol1 Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 X F 218-01-5219 Oct 15, Maryland Director 83 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "naturel", or Items 23s or 28e-1 show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Carroll Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 1705 Fawn Way 21048 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after i Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Samuel Cucina Anna Baygone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Lonnie D. Mazza (Son) 1705 Fawn Way Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department ( 4 Donation 5 Other (Specify) injury Meadowridge 2-4-2004 Elkridge, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, MD 21228 permit. Departr 21. Signature of Funeral Service Licenses Dema Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus on each line Immediate Cause (Final disease or condition resulting in death) Physician minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\sumsymbol{\text{Yes}}\) Yes 2 \(\sumsymbol{\text{V}}\) No 3 Ectopic pregnancy į Month Day Year 4☐Pregnant at time of death detached 9 Unknown ģ Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, pe 2 10 No 3 Probably 4 Unknown page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an Jas autopsy performe certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2/1/0 2 ER/Outpatient 3□ DOA Certification: To 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Limitural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of Marylar	•	artment of			Reg. No.	03717
Physic /Medi Exami	ical	Decedent's Name (First, Middle, Last     MINNIE A MASO     A. Facility Name (If not institution, give	N		4b. City, Tow	n, or Location of De	2. Date of De Month FEBRU	Day Yea	7:00A
Funeral Director		214-22-4012			BA If Under 1 Ye Months Da				irthplace (State or Foreign Country) NC
e Maryland e-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD N / F		ty, Town or Lo	cation LTIMOF	RE			10d. Inside City Limits 1    Yes 2 □ No
th with th	Funeral Director	10e. Street and Number 4800 SETON DRIV	/E		10f, Zip Cod	21207		10g. Citizen of What US	
n 72 hours after death with the Maryland n 72 hours after death with the Maryland "netural", or items 23e or 28e-f show realisal Extratinest be multimed at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tes 2 MNo If Yes, Give Year or Dates:		Was Decedent If Yes, specify C		(Specify Yes or No erto Rican, etc.)	o- 14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. BLACK
- c - 3	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12) 1 2	ucation de completed) College (1-4or 5+)	(Give	DO NOT use re	ne during most of a		16b. Kind of Busines  ASSEMB	,
be file ntal Hy od oth	To Be C	17. Father's Name (First, Middle, Last)  ROBERT ALLEN  19a. Informant's Name/Relationship (T	ivne Printl			18. Mother's MARTH	lame <i>(First, Middle,</i> IA WILLI	Maiden Sumame)	
es 1 ar of Hea of Hea of Item		SOLOMON HARP II  20a. Method of Disposition  1 \times Burial 2 \( \times \) Cremation 3 \( \times \)  4 \( \times \) Donation 5 \( \times \) Cher (Specify,	II, SON  Removal from State	1060	01 GREI esition (Name of matory or other	ENMOUNTA	AIN CIR,	er, City or Town, State COLUMBI  20c. Location - City of OWING MI	A MD 2104 or Town, State
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens		1 2	2. Name and Ad	dress of FacilitHC	WELL FU	NERAL HO	ME
Physician /Medical		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	tion	pnem		iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Examiner	lner	Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a 'o seq	rtensi	on				3yrs
cate be executed physician and the burial-transit	Ical Examiner	that initiated events resulting in death) Last	c. Due to (or as conseq		Ulco	<b>~</b>			3 months
eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnance of the second of the sec	Il death 3	⊒Ectopic pregna □ Other (s <i>pecify</i>			23d. Date of d Month	lelivery Day Year
quires that the d n signed by the	þ	Part II. Other significant conditions co	ntía	sulting in the u	nderlying cause	given in Part I.	100	obacco use contribute Yes 2 No 3 1	to the cause of death?  Probably 4 □Unknown
	Completed	Dyspl	nagra				24a. Was autor perfo 1 Yes	an 24b. Were prior to death? 2 No 1 \( \text{Ye} \)	autopsy findings available o completion of cause of ?
Attending Physician: The refeath. sctor; After this certificate by the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. I	0		one) dence 6 □Other (Sp how injury occurred	pecify)
To the Hospital or Attentwithin 24 hours after deall To the Funeral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Special	fy) 			City or To		
the Hosp in 24 hou the Funer apletely fil	ledical	(Check only 2   Medical Exam	vsicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	vestigation, in m	ny opinion, death o	ice, and due to the courred at the time,	date and place, and di	ue to the cause(s)
or With	2	29b. Signature and the of certifier		sician		ense number		29d. Date signed (Mon	
V		30. Name and address of From who con Nnaemeka Ag  31. Date filed (Month, Day, Year)	ajelu 7445	n 23a) (Туре. Е Г	Print)	Branch	Rd, He	n Burnie	MD 21060
St Regis	ate : trar	reme 4 A 200	32. Registrar's Signa	La	Asa s	41			

			For State Registrar	State of Marylan	d / Depa		lealth and N	•	ne 200	4 03718
			1. Decedent's Neme (First, Middle, Las					2. Date of Death Month	Dey_Yeer	3. Time of Death
	Physici /Medic		KEBECCA S.	MCCARTI	44				05 05	
	Examin		4a. Fecility Name (If not institution, give	street and number)			r Location of Death		4c. County of Dee	əth
			MERCY MEDICAL	CENTER		BALTI			N/A	
	Funeral Director		5. Social Security Number 6. S 234-90-4758  Usuel Residence of Decedent	ex	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 17	ear) C	rthplace (State or Foreign Country) st Virginia
death with the Maryland	Mot		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Mar	it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It a Medical Examiner must be notified at	tor	Maryland Bal	timore		Γ	undalk			1 ☐ Yes 2% No
th the	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?
th wi	23a		8027 Wallace F	Road			21222		United S	tates
	E E	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Bleck, Wh	
afe o	P E	J.	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No			Specify:	
ithin 72 hours after	ura!	d by	3 Widowed 4 Divorced	Year or Dates:					W	hite
72.	fag.	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king 16t	o. Kind of Business	s/Industry
	Then M	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	<i></i>		•			
A B	Hygie other i		17. Father's Name (First, Middle, Last)	4 Years		Office	Manager 18 Mother's Nam	e (First, Middle, Mai	T. R. K	lein
	od of	Be	Ernest Arthur S						,	
2	and Mental is marked raumatic ev	2	19a. Informant's Name/Relationship		10h Maili	na Addrass /Straat		7 J. Saylo ral Route Number, C		Zin Code)
Man d2st	h an 7 is r traur		Mr. Justin McCar	**				Dundalk, M		21222
1 and	Health em 27 ther tr		20a. Method of Disposition			sition (Name of			. Location - City o	
Saitimor Jermit. Pages	Department of Heals Important: If Item 2 any injury or other once.		14⊡Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	matory or other pla				
TIT T. Pe	rtant		*4 □ Donation S □ Other (Specify 21. Sunature of Frineral Sunctions)		-		dns. 2/11	1/2004	Beckley,	West Virgini
	Depa Impo any ir		21. Signature of Frineral Surface Open	12/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	Du		Funeral H	iome of Du		
	0240		Olo Baril Enter the disease or com	alications that according door	79	22 Wise	Ave. Dun	dalk, Mar	yland 2	1222 Approximate
- /	nysician Medical kaminer		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a conseq	uence of):	CANO				Interval Between Onset and Death
68 f 6U, lificate be executed		dical Examiner	iff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq  c						
Geath cert		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
Ords, P.O	signed by	by	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobac		to the cause of death?
	neen Shoulk	etec								
VICAL MECOLUS, ician: The law requires 1	ate has page 2	Completed						24a. Was an autopsy performed 1 ☐ Yes 255	prior to death?	tutopsy findings available completion of cause of
/ICS	th. : After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Manager A				th (Check only one)		
Physi	this o	ို	1 ☐ Yes 2 No			IL 3 DOA		ome 5 Residenc		ecify)
	Viter	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe how	injury occurred	
UIVISION I or Attending	lor: / the f	Certification:	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □No			
or At	irect hrect n by	E	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti y)	reet, factory, office		28f. Location (Stree City or Town, S	it and Number or F State)	Rural Route Number,
Cospital	within 24 hours after death.  To the Funerel Director: After this certific: completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	nysician: To the best of my kno niner: On the basis of examina	wledge, deat	h occurred at the tr	me, date and place,	and due to the caus	e(s) and manner a	s stated.
the H	the F nplete	Medicai	one)	and manner stated.						
0	To	2	29b. Signature and title of certifier	0		29c. Licens	se number		Date signed (Mon	
	- /		might	Lo MD.		DA	3434		4/5/5	1004
	10		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	Λ			ROO4 MD 21202
	1		WIGHT D	IM, M,D, 6	227 5	T. PAUL	. PLAC	E BALT	IMORE 1	MD 21202
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 15x If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 15, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 X F Yrs. 80 June Pennsylvania 211-12-6495 Director Usual Residence of Decedent 10d. Inside City Limits 10a. Sfate 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director Baltimore Maryland n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 United States 6400 Everall Ave. Apt 410 itams 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Exercites once. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing 12 yrs. Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Yahner Hilda Υ. Biller 2 Raymond 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Baltimore Street Aberdeen. Maryland 21001 Mr. Charles F. Miller / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 AOther (Specify) Entonbment Feb. 7, 2004 Woodlawn, Maryland Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp 21214 Baltimore, MD Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Inferval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MEHasturic 11cnows /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? be detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? res 212 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 12 Inpatient Other: 1 ☐ Yes -2 ⊞ No ၉ 2 ER/Outpatienf 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After the Funeral Director of the funeral D Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, sfreet, factory, office building, etc. (Specify) 4 Homicide Fercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUNDE 301 BAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004 Pil some

DHMH 17 Rev 1/2001

ORIGINAL

	THE RESIDENCE OF THE PARTY OF T
Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
Otal - Alderdond / Department of Li	colth and Mantal Hygiene O O O

	1 - State Registrar		Cer	tificate of Dea	alli	Reg	3. No.	
	1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	
sician edical	1101100	nne Mar	tin			Febluary	4 200	
miner	4a. Facility Name (If not institution, SINAI HOSPITAL	give street and number) OF BALTIMERE		4b. City, Town, or Local BALTIMERE			4c. County of De	ath I/A
eral ctor			(In yrs. last birthday) Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, ) Oct. 29,	(ear) 9. B 1969 Ma	irthplace (State or Fore Country) aryland
lor	Usual Residence of Decedent	3-1				,		
4	10a. State 10b. County		10c. City, Town or Lo Baltimore					10d. Inside City Lim
ctor	Maryland N/A							
Dire	10e. Street and Number			10f. Zip Code 2121	5	10	g. Citizen of What ( USA	
la la	2434 Belvedere	AVenue	in 11.0			city Yes or No-		nerican Indian,
event, the Medical Exemples of the Inclined at Be Completed by Funeral Director		Armed Forces?		Was Decedent of Hispan of Yes, specify Cuban, Mi 1 ☐ Yes 2√2 No Sp	lexican, Puerto F	Rican, etc.)	Black, Wh	
d by		Year or Dates:	40- 0	de alla Maria Carriadian		1	6b. Kind of Busines	
completed	15. Decedent' (Specify only highest	s Education grade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of workii		OD. KING OF CUSINES	Samoustry
d L	Elementary/Secondary (0-12)	College (1-4or 5+	-)	urses Aid			Medical	
C C		.ast)	1		Mother's Name	(First, Middle, M		
To Be		2			Sharon	Conolle	у	
T T	19a. Informant's Name/Relationsh	ip (Type, Print)		ng Address (Street and I				
Tr.	Sharon McArdle	Mother	4	Sunny Meado	w Ct.	:302 Ba1	timore, N	Maryland21
any injury or other to once.	20a. Method of Disposition  1 X Burial 2 Cremation	3 □Removal from State	20b. Place of Dispo cometery, crea Pine Gro	esition (Name of matory or other place) ve Cemetery			Oc. Location - City ( [t. Airy,	
y injury	21. Signature of Funerat Service L			2. Name and Address of urgee-Henss		Funeral	Home Inc	21211
a d	Jum	13. Her	3	631 Falls R	load. Ba	ltimore.	Maryland	1,
	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death. Do not en	ter the mode of dying, su	uch as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Deatl
ian	Immediate Cause (Final disease or condition	SEPS IS						14 days
ical	resulting in death)	Due to (or as a	consequence of):			1.1		
nor	1		pneumania					141
iner	Sequentially list conditions	b						14 days
<u> </u>	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying	b	ship consequence of:					14 days
<u> </u>	Sequentially list conditions, Tany, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consèquence of):					14 days
<u> </u>	Taily, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a						14 days
the burial-transit	T any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consèquence of):					14 days
the burial-transit	T any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):			-	23d. Date of	14 days
the burial-transit	T any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d	a consequence of):  of pregnancy 2 Fetal death 3	□Ectopic pregnancy			23d. Date of o	delivery Day Year
the burial-transit	T any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d	a consequence of):  of pregnancy 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				
detached for use as the burial-transit  Physician/Medical Examiner	If FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes   2   Who    1   Other significant conditions    1   Other significant conditions	c. Due to (or as a d.  23c. If yes, outcome 1  Live birth 4  Pregnant at 9 Unknown	a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(	Other (specify)	n Part I.	23e. Did tob	Month	Day Year
be detached for use as the burial-transit  by Physician/Medical Examiner	If reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d.  23c. If yes, outcome 1  Live birth 4  Pregnant at 9 Unknown	a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(	Other (specify)	n Part I.		Month	Day Year
be detached for use as the burial-transit  by Physician/Medical Examiner	If reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d.  23c. If yes, outcome 1  Live birth 4  Pregnant at 9 Unknown	a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(	Other (specify)	n Part I.	1 ☐ Ye	Month  acco use contribute s 2 \( \text{No} \) 3 \( \text{T} \)	Day Year to the cause of death Probably 4 Onkn autopsy findings avai
pe 2 should be detached for use as the burial-transit mpleted by Physician/Medical Examiner	If reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d.  23c. If yes, outcome 1  Live birth 4  Pregnant at 9 Unknown	a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(	Other (specify)	n Part I.	1  Ye 24a. Was ar autops	Month  acco use contribute  s 2 \( \text{No} \) 3 \( \text{Order} \)  24b. Were prior ideath	Day Year  to the cause of death Probably 4 Donkr  autopsy findings avaito completion of causers
page 2 should be detached for use as the burial-transit	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d	a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(	☐ Other (specify)		1  Ye  24a. Was ar autops perform 1  Yes 2	Month  acco use contribute s 2 No 3   24b. Were prior death	Day Year  to the cause of death Probably 4 Donkr  autopsy findings avaito completion of causers
rector, page 2 should be detached for use as the burial-transit  Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of):  of pregnancy 2 Fetat death 3(time of death 5(	Other (specify)  underlying cause given in	5. Place of Deatl	1  Yes 2	Month  acco use contributes  \$ 2 \sum No 3 \sum   24b. Were prior death 1 \sum Y \text{  25c. Were prior death 1 \sum Y \text{  2	Day Year  to the cause of death Probably 4 Onkr  autopsy findings avait to completion of cause (7) (es 2 No
al director, page 2 should be detached for use as the burial-transit.  To Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c.  Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death but 1 Pregnant at 2 Date of Injury	a consequence of):  a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(  ut not resulting in the unit 2 ER/Outpatie y 28b. Time	Other (specify)  underlying cause given in	<ol> <li>Place of Death</li> <li>Vursing Ho</li> </ol>	1  Yes 2	Month  acco use contributes  s 2 No 3   24b. Were prior death 1 Y	Day Year  to the cause of death Probably 4 Onkr  autopsy findings avait to completion of cause (7) (es 2 No
al director, page 2 should be detached for use as the burial-transit.  To Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c.  Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death but 1 Pregnant at 1	a consequence of):  a consequence of):  of pregnancy 2 Fetal death 3( time of death 5(  ut not resulting in the unit 2 ER/Outpatie y 28b. Time	Other (specify)  underlying cause given in  26  nt 3 DOA  Other: by 28c. Injury at Work?	<ol> <li>Place of Death</li> <li>Vursing Ho</li> </ol>	1 Ye  24a. Was ar autops perform 1 Yes 2  Check onlone me 5 Reside	Month  acco use contributes  s 2 No 3   24b. Were prior death 1 Y	Day Year  to the cause of death Probably 4 Onkn autopsy findings avait to completion of cause (7) (es 2 No
al director, page 2 should be detached for use as the burial-transit.  To Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d	a consequence of):  a consequence of):  of pregnancy 2	Other (specify)  underlying cause given in  26  ont 3 DOA Other:  of 28c. Injury at Work?  M 1 Yes	3. Place of Deatl 4 □ Nursing Ho	1 Ye  24a. Was ar autops; perform 1 Yes 2  1 Check onl one me 5 Reside 28d. Describe ho	Month  acco use contribute s 2 No 3  24b. Were prior death 1 Y  acco use contribute s 2 No 3  Contribute s 3  Contribute s 2 No 3  Contribute s 3 No 3  Contribute s 4 No 3  Contribute s 5 No 3  Cont	Day Year  to the cause of death Probably 4 Onkn autopsy findings avail to completion of cause (7) (es 2 No
al director, page 2 should be detached for use as the burial-transit.  To Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	c. Due to (or as a d	of pregnancy 2 Fetal death 3 ( time of death 5 ( at not resulting in the control of the control	Other (specify)  underlying cause given in  26  ont 3 DOA Other:  of 28c. Injury at Work?  M 1 Yes	3. Place of Deatl 4 □ Nursing Ho	1 Ye  24a. Was ar autops perform 1 Yes 2  1 Check onlone me 5 Reside 28d. Describe ho	Month  acco use contribute s 2 No 3  24b. Were prior death 1 Y  acco use contribute s 2 No 3  Contribute s 3  Contribute s 2 No 3  Contribute s 3 No 3  Contribute s 4 No 3  Contribute s 5 No 3  Cont	Day Year  to the cause of death Probably 4 Donkin autopsy findings avail to completion of cause (7) (9) (9) (9) (9) (9) (9) (9) (9) (9) (9
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit ical Certification: To Be Completed by Physician/Medical Examiner	Taily, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ons contributing to death but (Month, Da) 28a. Date of Injunded 28a. Date of Injunded 28a. Place of Inj	of pregnancy 2 Fetal death time of death  t not resulting in the telephone y Year)  28b. Time t njury  At home, farm, s c. (Specify)	Other (specify)  underlying cause given in  26  ont 3 □ DOA Other:  of 28c. Injury at Work?  M 1 □ Yes  treet, factory, office	3. Place of Deatl 4 Nursing Ho 2 No	1  Ye  24a. Was ar autops perform 1  Yes 2  1  Check onl one 1  Reside 28d. Describe ho  28f. Location (Str. City or Town	Month  acco use contributes  s 2 No 3 The contribute of the contri	Day Year  a to the cause of death Probably 4 Onkn autopsy findings avait to completion of cause ? es 2 No  Specify)  Rural Route Number, r as stated.
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit ical Certification: To Be Completed by Physician/Medical Examiner	Taily, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death but (Month, Da) gation not be inned 28e. Place of Injury building, etc.  28e. Place of Injury building, etc.	of pregnancy 2 Fetal death time of death  t not resulting in the telephone y Year)  28b. Time t njury  At home, farm, s c. (Specify)	Other (specify)  underlying cause given in  26  ont 3 □ DOA Other:  of 28c. Injury at Work?  M 1 □ Yes  treet, factory, office	3. Place of Death 4 Nursing Ho 2 No date and place, on, death occur	1 Ye  24a. Was ar autops perform 1 Yes 2  1 Check onl one me 5 Reside 28d. Describe ho  28f. Location (St. City or Town and due to the cared at the time, da	Month  acco use contributes  s 2 No 3 The contribute of the contri	Day Year  to the cause of death Probably 4 Onkn autopsy findings avail to completion of cause (? Yes 2 No Specify)  Paral Route Number, as stated. due to the cause(s)
led in by the funeral director, page 2 should be detached for use as the burial-transit Certification: To Be Completed by Physician/Medical Examiner	Taily, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death but (Month, Da) gation not be inned 28e. Place of Injury building, etc.  28e. Place of Injury building, etc.	of pregnancy 2 Fetal death time of death  t not resulting in the telephone y Year)  28b. Time t njury  At home, farm, s c. (Specify)	Other (specify)  Inderlying cause given in  26  Other:  28c. Injury at Work?  M 1   Yes  treet, factory, office  th occurred at the time, expecting attention, in my opinion.	5. Place of Deatl 4 Nursing Ho 2 No date and place, on, death occurr	24a. Was ar autops perform 1 Yes 2 n Check onl one 28d. Describe ho 28f. Location (Str. City or Town and due to the cared at the time, day	Month  acco use contributes  s 2 No 3   1 24b. Were prior of death 1 Years  nce 6 Other (S w injury occurred  reet and Number or State)  suse(s) and manner at eand place, and contributes and place, and contributes are and place, and contributes are signed (Months)	Day Year  a to the cause of death Probably 4 Onkn a autopsy findings avail to completion of cause (? Yes 2 No Specify)  Pural Route Number, r as stated, due to the cause(s)
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit ical Certification: To Be Completed by Physician/Medical Examiner	Taily, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of Death   Not the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of Death   Not the past 12 months? 1   Yes 2   No 9   Unknown  25. Was case referred to medical examiner? 1   Yes 2   No 9   Unknown  26. Was case referred to medical examiner? 1   Yes 2   No 9   Unknown  27. Manna of Death   Not the past 12 months of Death   Not t	c. Due to (or as a d	of pregnancy 2 Fetal death 3 ( time of death 5 ( at not resulting in the or	Other (specify)  Inderlying cause given in  26  Other  28c. Injury at Work?  M 1 Yes  treet, factory, office  th occurred at the time, one of the occurred at the time, or one occurred at the time, or	3. Place of Death 4 Nursing Ho 2 No date and place, on, death occur	24a. Was ar autops perform 1 Yes 2 n Check onl one 28d. Describe ho 28f. Location (Str. City or Town and due to the cared at the time, day	Month  acco use contribute s 2 No 3   24b. Were prior death 1 N  nce 6 Other (S w injury occurred  reet and Number or , State)	Day Year  a to the cause of death Probably 4 Onkn a autopsy findings avail to completion of cause (? Yes 2 No Specify)  Pural Route Number, r as stated, due to the cause(s)
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit ical Certification: To Be Completed by Physician/Medical Examiner	Taily, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d	of pregnancy 2 Fetal death 3 (time of death 5 (at not resulting in the strong or the strong of the s	Other (specify)  Inderlying cause given in  26  Other  28c. Injury at Work?  M 1 Yes  treet, factory, office  th occurred at the time, one of the occurred at the time, or one occurred at the time, or	S. Place of Deatl 4 Nursing Ho 2 No date and place, on, death occurr	1 Ye  24a. Was ar a autops; perform 1 Yes 2  1 Check on one  28d. Describe ho  28f. Location (Str. City or Town and due to the cared at the time, days are a street at the time, and the street at the street at the time, and the street at the street	Month  acco use contributes  \$ 2 \sum No 3 \subseteq  24b. Were prior death 1 \subseteq  Year and Other (S)  w injury occurred  reet and Number or , State)  ause(s) and manner ate and place, and color  and Date signed (Month)  Telsony 4	Day Year  a to the cause of death Probably 4 Junkr  a autopsy findings avait to completion of cause ?  es 2 I No  Specify)  r Rural Route Number, as stated, due to the cause(s)  onth, Day, Year)

			Please Type or Print in Blace State of Maryland / I  1- For Registrar	Depa	actible ink. Ensure A artment of Health and I tificate of Death	Mental Hygie	ne <sub>2004</sub>	03721
					unicale of Dealif	Reg 2. Date of Death	No. The second s	3. Time of Death
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> JOSEPH EUGENE	V - 17 T	NOTE	Month	Day Year	
	/Medic			MCKE	NZIE		4, 2004	8:00 P M
	Examin	er	4a. Fecility Name (If not institution, give street and number)  8219 OLD JUMPERS HOLE ROAD		4b. City, Town, or Location of Death		4c. County of Death	VD FIT
					MILLERSVILLE  If Under 1 Year   If Under 24 Hrs.	10.5	ANNE ARUN	
	Funeral Director		5. Social Security Number  212-22-9981   6. Sex   100 M 2 F   7. Age (In yrs. last bit)  1 Usual Residence of Decedent	Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Pay, Y 9/11/192	ear) Cou	place (State or Foreign htry) STOWN, PA
	and		10a. State 10b. County 10c. City, Tow	vn or Lo	cation		1	Od. Inside City Limits
	Mary f aho	ō	MD ANNE ARUNDEL MII	LLER	SVILLE			1 Yes 2 No
	28a-	Director	10e, Street and Number		10f. Zip Code	100	Citizen of What Cour	ntrv?
	with	۵	8219 OLD JUMPERS HOLE ROAD		21108	-		•
	eath	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13 \	Was Decedent of Hispanic Origin? (S		U.S.A. 14. Race - Americ	an Indian
	iter d	Ľ,	Armed Forces?  1 □ Never Married 2 ★ Married 1 □ Yes ★ No	10.1	f Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
36	rs af	by F	3 Widowed 4 Divorced Year or Dates:	-	I □ Yes 💥 🗓 No Specify:		Specify: WHI	TE
21215-0036	72 hours after death with the Maryland natural', or tems 23a or 28a-f ahow deat Exambat must be multind at			. Deced	dent's Usual Occupation	16	o. Kind of Business/In	dustry
7.	in 7	piet	(Specify only highest grade completed)	(Give life. I	kind of work done during most of wor DO NOT use retired)	king		•
77	within jene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CAR	PENTER		SELF EMPLO	YED
g	Hygi other	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma.		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 Is marked other than "neturat", or items 23s or 28s-f show other traumatic avent, its Mudical Examilian marked than indiffied at	To B	LEONARD McKENZIE		EDNA S	SMITH		
3	2 should and Men Is marke sumatic	_	19a. Informant's Name/Relationship (Type, Print) 19t	b. Maitir	ng Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip	Code)
	Health a tem 27 ls		ROSA M. McKENZIE - WIFE 82	219	OLD JUMPERS HOLE	ROAD, MIL	LERSVILLE.	MD 21108
ē	es 1 a of Hea f Item r othe		20a. Method of Disposition 20b. Place of compate	of Dispo	sition (Name of natory or other place)		. Location - City or To	
Ë	Pages nent of int: If Its iry or o		13 Burial 2 ☐ Cremation 3 ☐ Removal from State  14 ☐ Donation 5 ☐ Other (Specify)  GLEN	1		′2004 G	LEN BURNIE	. MD
Baltimore,	그 된 원 등	1 19	21. Signatur / 1 Juneral Service Lice see	1	THE RESIDENCE OF THE PARTY OF T		AL HOME, P	
Ä	permi Depa Impo any ir	. //	KELLY GRAGORY FINK #M01148	4	26 CRAIN HIGHWAY			
ri .	370		23a. Part1. Enter the disease of complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate
			Immediate Cause (Final					Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)  a. Due to (or as a c int equence	VM C	~			
	Examiner	lii		OI).				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):				
	be executed sicien and burial-transit	Examin	cause. Enter Underlying Cause (Lisease of May ) that initiated events c.				-	
4	executed n and ial-transit	Exa	resulting in death) Last  Due to (or as a consequence	of):				
3	e be ex sicien e burial	ä	d					
89	ificat g phy as th	edic						
Вох	death certificate b e attending physion of for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  □ Nast 12 months?  □ Pregnant at time of death		Ectopic pragnancy Other (specify)		23d. Date of delive Month	ery Day Year
P.0.	O 0 X	Jysi	1 UYes 2 No 9 Unknown 9 Unknown					
	law requires that the as been signed by th 2 should be detache		Part II. Dther significant conditions contributing to death but not resulting it	in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Division of Vital Records,	w requires that s been signed b should be deta	d by	Chronic Obstructure les	40 [	)1seane	1 Nes	2 □ No 3 □ Prob	ably 4 Unknown
<u> </u>	w req beer shou	Completed		1		24a. Was an	24b. Were auto	psy findings available
Re	0 - 0	Ē				autopsy performe	prior to co	mpletion of cause of
B	ician: Th certificate rector, pag	e Co	25. Was case referred to medical			1 ☐ Yes 2Ã.	XNo 1 □ Yes	2 <b>A</b> ) No
$\equiv$	Physician: this certificatal director,	o Be	examiner?  1 Yes XX No  Hospital: 1 Inpatient 2 ER/O		0.0	th (Check only one)	а Понь « / о / о	
o	Phys rthis ral dii	-	27. Manner of Death 28a. Date of Injury 28b.	Time of	1 3L DOA 4L Nursing H	28d. Describe how	e 6 Other (Specificial Control of the Control of th	Y)
O	Attending I ir death. ector: After by the funer	tion	A E Natural 5 ☐ Pending (Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,	
S	I or Attendii after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fa	arm. str	_	28f. Location (Stree	t and Number or Rura	I Route Number.
Ξ	after Dire	Certification;	4 Homicide determined building, etc. (Specify)	,	,	City or Town, S		
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	e, death	occurred at the time, date and place restigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
	vithin o the omple	Me	29b. Signature and title of pertifier		29c. License number	29d.	Date signed (Month,	Day, Year)
	F > F 0		· Asily M	·D	D50470	d	2/5/04	
_	10		30. Name and address of person who completed cause of death (Item 23a)  SRIDIAR ATLUM, 810915	Type,	Print) Hway	Paradeur	MD 21	122
1	Sta Registr		31. Date filed (Month, Day, Year)  September 2004  32. Registrar's Signature	1	10-11			
DH	MH 17 Rev 1/2	-1	FEB 1 0 2004 / Server	1 100	- Jaguar Rod			

ORIGINAL

Reginal 04-0819 AKG

Baltimore, Maryland 21215-0036

	State Registrar Unpend Item#23	a,21,28a-f,Per l	ME,G826	15/4/104eg	Dealli	2. Date of De	Reg. No	0.	3. Time of Death
n	1. Decedent's Name (First, Middle, Last)  Reginald	Mcko	<b>7.77</b>			Month Janua	Da	30, Yea	ır i
al _	4a. Facility Name (If not institution, give st		у	4b. City, Town, o	or Location of Dea		_	c. County of De	
	Good Samaritan Hos	_		Baltimo				N/A	
	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday	) If Under 1 Year	If Under 24 Hrs		rth	9.6	Birthplace (State or Foreig Country)
	218-789691 <sup>1</sup> X	<sup>M 2□ F</sup> 42	Yrs.	Months Days	Hours Min	1-27-6	31	Ba	ltimore, M
- 1-	Usual Residence of Decedent	10c Cit	y, Town or L	oastion					10d. Inside City Limits
	10a. State 10b. County								ty⊡Yes 2 □ No
_	Md. N/A	I	Balti				100 0	itizen of What	
	10e. Street and Number	~ .		10f. Zip Code			-		Country
H	528 W. Preston	St. 2. Was Decedent Ever in U	S 13	2120		Specify Yes or No		SA 14. Bace - A	merican Indian,
	11. Marital Status	Armed Forces?		Was Decedent of I If Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		Black, W	
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 80-	-81	1 ☐ Yes 2 🛣 No	Specify:			Specify:	Black
-	15. Decedent's Educ	ation	16a. Dece	edent's Usual Occup	pation		16b. h	Kind of Busine:	ss/Industry
Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	e kind of work done DO NOT use retire	ed)	arking			
5	12			Odd Jol	b		00	dd Job	
מ	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maide	n Sumame)	
2	Carlton E.	McCoy			Anni	e McO	Соу		
	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ling Address (Street	t and Number or F	Rural Route Numb	er, City	or Town, State	a, Zip Code)
7	Tonya McCoy S				urne Rd				land 2123
8	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	1 /	Place of Disp cemetery, cre	position (Name of ematory FOT es	Set.	Date	20c. L	Location - City	or Town, State
	* 4 ☐ Donation 5 ☐ Other (Specify)		d.VEt	.Garrise	on $2-9$				ills,Md.
	21. Signature of Funeral Service License		र्म	22. Name and Addre	ess of Facility	Erra on o	1 0	D A	
1	▶ Ljoyd M. Est	CD		DUCP DI	others	runera.	T DE	er, P. A	
-	Mary In Cons				ess of Facility Others aw Plac			er,P.A re,Md.	
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat						er,P.A re,Md.	Approximate Interval Between
34.	shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deat	th. Do not er	nter the mode of dyi	ing, such as cardia			er,P.A re,Md.	Approximate
	shock, or heart failure. List only one	cations that caused the deat e cause on each line.	th. Do not er	nter the mode of dyi	ing, such as cardia			er,P.A re,Md.	Approximate Interval Between
	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ations that caused the deate cause on each line.  Alcohol and  Due to (or as a consequence)	Narcoti	nter the mode of dyi	ing, such as cardia			er,P.A re,Md.	Approximate Interval Between
Juner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ations that caused the deat e cause on each line.  Alcohol and	Narcoti	nter the mode of dyi	ing, such as cardia			er,P.A re,Md.	Approximate Interval Between
xaminer	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Alcohol and Due to (or as a consequence)	Narcoti Narcoti Juence of): Juence of):	nter the mode of dyi	ing, such as cardia			er,P.A	Approximate Interval Between
	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ations that caused the deate cause on each line.  Alcohol and  Due to (or as a consequence)	Narcoti Narcoti Juence of): Juence of):	nter the mode of dyi	ing, such as cardia			er,P.A	Approximate Interval Between
0	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Alcohol and Due to (or as a consequence)	Narcoti Narcoti Juence of): Juence of):	nter the mode of dyi	ing, such as cardia			er,P.A	Approximate Interval Between
0	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:	Alcohol and Due to (or as a consect Due to (or as a co	Narcoti puence of): puence of): puence of):	c Introdicat	ing, such as cardia			er, P. Are, Md.	Approximate Interval Between Onset and Death
0	shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?	ations that caused the deate cause on each line.  Alcohol and  Due to (or as a consequence of the consequen	Narcoti quence of): quence of): quence of): quence of):	□Ectopic pregnance	ing, such as cardia				Approximate Interval Between Onset and Death
m	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant	Alcohol and Due to (or as a consect Due to (or as a co	Narcoti quence of): quence of): quence of): quence of):	c Introdicat	ing, such as cardia			23d. Date of	Approximate Interval Between Onset and Death
Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a consect to (or a)))).	Narcoti puence of):	□Ectopic pregnanc □ Other (specify)	ing, such as cardia	ac or respiratory a	arrest,	23d. Date of Month	Approximate Interval Between Onset and Death
by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	Due to (or as a consect to (or a)))).	Narcoti puence of):	□Ectopic pregnanc □ Other (specify)	ing, such as cardia	ac or respiratory a	arrest,	23d. Date of Month	Approximate Interval Between Onset and Death D
by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	Due to (or as a consect to (or a)))).	Narcoti puence of):	□Ectopic pregnanc □ Other (specify)	ing, such as cardia	23e. Did	tobacco	23d. Date of Month  use contribute 2 □ No 3 □	delivery Day Year  to the cause of death?  Probably 4 DUnknow
by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	Due to (or as a consect to (or a)))).	Narcoti puence of):	□Ectopic pregnanc □ Other (specify)	ing, such as cardia	23e. Did	tobacco Yes 2 s an ppsy ormed?	23d. Date of Month  use contribute 2 No 3 2	Approximate Interval Between Onset and Death  delivery Day Year  a to the cause of death?  Probably 4 Dunknow autopsy findings availab to completion of cause of
Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	Due to (or as a consect to (or a)))).	Narcoti puence of):	□Ectopic pregnanc □ Other (specify)	ey	23e. Did 1   24a. Wa auto	tobacco Yes 2 s an oppsy ormod? 2 □ N	23d. Date of Month  use contribute 2 No 3 2	Approximate Interval Between Onset and Death Onset and Death
Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect to large to lar	Narcoti puence of): quence of): quence of): quence of): quence of): survey al death 3 death 5 sulting in the	□ Ectopic pregnanc □ Other (specify) □ underlying cause gi	ing, such as cardial from the second	23e. Did 1 1 24a. Wat aut perf	tobacco Yes 2 san ppsy ormed? 2 \( \text{N} \) one)	23d. Date of Month  Duse contribute 2 No 3 1  24b. Were prior death	delivery Day Year  to the cause of death?  Probably 4 Dunknow autopsy findings availab to completion of cause of ?  es 2 \sum No
To Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the birth 2   Fett 4   Pregnant at time of 9   Unknown tributing to death but not reserved.	Narcoti puence of): puence of)	□ Ectopic pregnand □ Other (specify) □ underlying cause gi	ey  Iven in Part I.  26. Place of Dother: 4 \( \text{Nursing} \) Nursing	23e. Did 1   24a. Wa auto	tobacco Yes 2 san ppsy ormed? 2 N one)	23d. Date of Month  Duse contribute 2 No 3 1 24b. Were prior death	delivery Day Year  to the cause of death?  Probably 4 Dunknow autopsy findings availab to completion of cause of ?  es 2 \sum No
lo Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions condition	Due to (or as a consequence of the consequence of t	Narcot in the Na	□Ectopic pregnanc □ Other (specify) underlying cause gi	ing, such as cardial from the such as cardial	23e. Did 1 □ 24a. Wataperi 1 ☑ Yes eath (Check only Home 5 □ Res 28d. Describe	tobacco Yes 2 s an ppsy ormed? N one) sidence how injutes	23d. Date of Month  Duse contribute 2 No 3 1 24b. Were prior death	delivery Day Year  to the cause of death?  Probably 4 Dunknow autopsy findings availab to completion of cause of ?  es 2 \sum No
To Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the birth 2   Fett and 1   Dunknown    Bospital: 1   Inpatient 2   Inpati	Narcot in the Na	□Ectopic pregnand □ Other (specify) underlying cause gi	ey  Iven in Part I.  26. Place of Dother: 4 D Nursing any at 10 Nursing 2 R No	23e. Did 1 24a. Wata perf 1 2 Yes eath (Check only Home 5 Res 28d. Describe	tobacco Yes 2 san ppsy ormed? 2 N one) sidence how injut	23d. Date of Month  Duse contribute 2 No 3 2  24b. Were prior death 1 2 4  6 Other (Sury occurred	delivery Day Year  to the cause of death?  Probably 4 Dunknow autopsy findings availab to completion of cause of ?  es 2 \sum No
To Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequence of the consequence of t	Narcoti puence of):  quence of)	□Ectopic pregnand □ Other (specify) underlying cause gi	ey  Iven in Part I.  26. Place of Dother: 4 D Nursing any at 10 Nursing 2 R No	23e. Did 1	tobacco Yes 2 s an pormed? 2 □ N one) sidence how inju	23d. Date of Month  use contribute 2 No 3  24b. Were prior death 1 Prior (Sury occurred	delivery Day Year  to the cause of death?  Probably 4 Tunknow autopsy findings available to completion of cause of specify)  Rural Route Number,
Certification; To Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions condition	Due to (or as a consect to or as	Narcoti  Narcoti  Juence of):	Ectopic pregnand Other (specify) underlying cause given to a control of the contr	ey  ey  even in Part I.  26. Place of De  ther: 4 \( \) Nursing  ury at  or Y?  Yes 2 \( \) No  etime, date and place	23e. Did 1 24a. Waau aut 1 29 Yes eath (Check only Home 5 Res 28d. Describe tinknown 28d. Location City or To Cedonia	tobacco Yes 2 s an opsy ormed? 2 N one) sidence how injut (Street a own, Sta	23d. Date of Month  use contribute 2 No 3 2  24b. Were prior death of the control	delivery Day Year  to the cause of death? Probably 4 Junknow autopsy findings available to completion of cause of specify)  Rural Route Number, elivery Battimore MD
Certification; To Be Completed by Physician/Medical E	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions condition	Due to (or as a consect of the building, etc. (Specification)  attions that caused the deat e cause on each line.  Alcohol and  Due to (or as a consect of the building, etc. (Specification)	Narcoti  Narcoti  Juence of):	Ectopic pregnand Other (specify) underlying cause given to a control of the contr	ey  ey  even in Part I.  26. Place of De  ther: 4 \( \) Nursing  ury at  or Y?  Yes 2 \( \) No  etime, date and place	23e. Did 1 24a. Waau aut 1 29 Yes eath (Check only Home 5 Res 28d. Describe tinknown 28d. Location City or To Cedonia	tobacco Yes 2 s an opsy ormed? 2 N one) sidence how injut (Street a own, Sta	23d. Date of Month  use contribute 2 No 3 2  24b. Were prior death of the control	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Probably 4 Junknow autopsy findings available to completion of cause of Probably Appecify)  Probably 4 Junknow Onset Completion of Cause of Probably Appecify Onset Completion of Cause of Probable Probable Onset Completion of Cause of Probable Onset Completion of Cause of Probable Onset Completion Onset
To Be Completed by Physician/Medical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consect of the best of examinations)  attions that caused the deat of examinations and the cause on each line.  Alcohol and Due to (or as a consect of the	Narcoti  Narcoti  Juence of):	DEctopic pregnanc Other (specify) underlying cause given to a continuous properties of the continuous p	ey  ey  even in Part I.  26. Place of De  ther: 4 \( \) Nursing  ury at  or Y?  Yes 2 \( \) No  etime, date and place	23e. Did 1 24a. Waau aut 1 29 Yes eath (Check only Home 5 Res 28d. Describe tinknown 28d. Location City or To Cedonia	tobacco Yes 2 s an opsy ormed? 2 N one) sidence how injut (Street a wm, Sta  Road e cause( i, date ar	23d. Date of Month  by use contribute 2 No 3 1  24b. Were prior death to 1 1 2 4  6 Other (Sury occurred  and Number or (e)  and Hazz (s) and manner or (e)	delivery Day Year  to the cause of death? Probably 4 Junknow autopsy findings available to completion of cause of specify)  Rural Route Number, elivery Battimore MD

Division of Vital Records, P.O. Box 68760,

THEDDINE M. KAR 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

				ype or Print in B					_	
			For State	State of Maryland				мептат нуди	ene 2004	03723
			Registrar		Cei	rtificate of	Deam	2, Date of Death	g. No.	3. Time of Death
П	Physicia	an	1. Decedent's Name (First, Middle, Last)	Mit	160	11		Month.	Day Yeer 2004	1 161 000
	/Medic		4a. Facility Name (If not institution, give s.	treet and number)	7)6	4b. City. Town. o	or Location of Deat	h	4c. County of Deetl	
	Examin	er	Bon Secours H				imore		N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Q Right	hplece (Stete or Foreign untry)
121	Director		216-20-0632	M 2XF 84	Yrs.			3-27-1	L9 Bal	tímore, Md.
	pur *		Usuel Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	f eho	ō	Md. N/A	Ro	ıltim	ore				MF Yes 2 No
	28a	rect	10e. Street and Number	100	CT C TIII	10f. Zip Code		10	g. Citizen of What Co	untry?
	h with	Funeral Director	2513 Calverton	Height Ave.		21216			USA	
	deet deet	ner		Was Decedent Ever in U.S     Armed Forces?	S. 13.	Was Decedent of H	Hispanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	or No	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 🗓 No	Specify:		Specify: B1	ack
5-003	be filed within 72 hours efter deeth with the Maryland ital Hygiene.  d other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	d by	3 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occur	nation	1	6b. Kind of Business/	Industry
15	in 72 in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking		,
212	filed with Hygiene. kther thai	mo	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Sal	es Cle	rk	- F	Hetch Co.	
힏	should be titled within and Mental Hygiene. marked other than smatic event, the Mental transments of the Mental transments.	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	aiden Sumame)	
<u>a</u>		70	Albert Brown				Ann		own	
Maryland	2 she and le m		19a. Informant's Name/Relationship (Typ						City or Town, State, 2	
	s 1 and 2 should f Health and Mer Item 27 ie marke other traumatic		Faye Tucker ( 20a. Method of Disposition	D)		3 Calve: osition (Name of	rton He	ight Ave	Balto M	Id. 21216 Town State
בסר	0 0		1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cre	matory or other pla	1			
altimore,	permit. Peges 1 a Department of Hea Important: If Item any injury or othe once.		* 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License			ham VA.			Cheltenh	
Ba	permit. Pege Department Important: If any injury or once.		Lloyd M. Este			Estep B	rothers	Funeral	Ser,P.A	21217
Ē			23a. Part1. Enter the disease, or compli	cations that caused the death	n. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	ARDI	071	Imon	Aur. 1	ADDE	~	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ue of):	10/01	/ /			
	Examiner		Sequentially list conditions, b	Meta	STO	tic h	LING	- Car	CER	
	sit sid	inei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	Can	100			
NE	be executed icherrand burial-transi	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):					
200		7	L.	Hereit Commence						
89	leath certificate attending physi	Physician/Medic								
Вох	endin use	M/W	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		□Ectopic pregnanc	v		23d. Date of deli	
B	s deat he att ed for	sicie	in the past 12 months?	4 Pregnant at time of de 9 Unknown		Other (specify)	,		Month	Day Year
P.O.	d by the	Phy	9 Unknown  Part II. Other significant conditions con	stributing to death but not reco	ulting in the s	ındarkını cauca dı	ven in Part I	23e. Did toba	acco use contribute to	the cause of death?
	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions con	tributing to death but not less	atting in the c	indenying cause gr	voit iii i ditti.		s 2□No 3□Pr	3.
Ö	w requir been si should	Completed						24a, Was an	24h Were au	itopsy findings available
Rec	he lav	dmo						autopsy perform	ed? prior to death?	completion of cause of
ta	sicien: The lav certificate has rector, page 2	Be Co	25. Was case referred to medical				26. Place of De	1 Yes 2 ath (Check only one	No 1 Yes	2 No
of Vital Records,	ysicia is cer direct	To B	examiner?	lospital: 1   Inpatient 2	ER/Outpatie	nt 3500A Ot	har		nce 6 Other (Spec	cify)
0 0	ng Ph Iter th neral		27. Manner of leath Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe how	w injury occurred	
Sio	uttendii death. ctor: A y the tu	catie	2   Accident investigation 3   Suicide 6   Could not be				]Yes 2□No	00(1 1: (0)	444	- I Double Affine
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office		City or Town,	eet and Number or Ru State)	irai Houle ivumber,
_	spitel ours a seref filled		29a. Certifier Certifying Phys	sician: To the best of my kno	wiedge, deal	th occurred at the ti	me, date and place	e, and due to the car	use(s) and manner as	stated.
	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only	ner: On the basis of examina and manner stated.	tion and/or in	nvestigation, in my	opinion, death occ	urred at the time, da	te and place, and due	to the cause(s)
	To the To	ž	29b. Signature and title of certifier	( - 0		29c. Licen	se number	29	d. Date signed (Monti	h. Dey, Year)
	5		J. A Ham. 17	In MD, Stap	1 phys	1c/de -	1080	27/	02-0	5-2004
			30. Name and address of person who co	2. 11/12.	23a) (Type	Print) C+	R4 -	MJ	217	23
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	SPR -1	DALTIM	ORE, MIC	)0100	A)
	Sta Regist	ate rar		004 Januar	w for	& Som	Kest "			
					-	f P				

Considerations (First, Messel, Justil 1998)  Fig. 1997   State of Consequence of				For State Registrar	State of	Marylan		artment of F	Health and M Death		giene	04	037	24
Sames Franklin Miles Sr.  Seventham of continuous power and namebral Clean Burnie  Foundation  Foundat					, Last)					2. Date of Dea	ath		3. Time of De	ath
Security Number   Four Internal Property   Security Number   Sec				James Frankli	n Miles	Sr.				-			5:35 P	М
Director  Direct				4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, o	or Location of Death		4c. Cour	ity of Death		
219-22-6938 TO MAN TO MORTH BY NOTE TO SEPT 10, 1928 TO MAN TO SEPT 10, 1928 TO MAN TO														
19   19   19   19   19   19   19   19				5. Social Security Number	6. Sex 7					(Month, Day	v. Year)	Cour	lace (State or Fo try)	reign
To See and Number  100. District and Number of Number Alexander Alexander  100. District and Number of Number Alexander  100. District and Number of		Director	ļ	219-22-6938		/3				Sep. 1	0, 192	עוויין פ		
Company   Comp		/land				10c. City	, Town or Lo	cation				1	0d. Inside City L	imits
Company   Comp		Man	ģ	MD Anne A	rundel	Gle	n Burr	ie					1 Tes 28	X No
Company   Comp		th the or 284	ire	10e. Street and Number				10f. Zip Code			10g. Citizen o	What Cour	try?	
Company   Comp		23a antb	rai	1618 Furnace Ro										
Emmediate Case (First Mode, Last)    Emmediate Case (First Mode, Last)   Interest Name (First Mode, Name	10	er de	nue		Armed For	ces?	S. 13.	Vas Decedent of H I Yes, specify Cub	Hispanic Origin? (Spe ian, Mexican, Puerto	ecify Yes or No- Rican, etc.)				
Emmediate Case (First Mode, Last)    Emmediate Case (First Mode, Last)   Interest Name (First Mode, Name	2	rs aft	by F		ff Yes, Give	X tes:		∏Yes 2∭ No	Specify:		Spec	ity: whi	te	
Emmediate Case (First Mode, Last)    Emmediate Case (First Mode, Last)   Interest Name (First Mode, Name	3	2 hou	ted				16a. Deced	lent's Usual Occup	pation		16b. Kind of	Business/In	dustry	
Milton Miles  We will be a second process of the second process of	10		pie		1	4or 5+)	life. I	DO NOT use retire	d)					
Milton Miles  We will be a second process of the second process of	' )	Marin Marin 1	S	8			Vendi	ng Machi	·					
Second Avenue S.W., Glen Burnie, MD 21061   Approximate of the second contract of the second cont	2	be fill Hall Hall Hall Hall Hall Hall Hall H	Be		Last)						Maiden Sum	ame)		
Second Avenue S.W., Glen Burnie, MD 21061   Approximate of the second contract of the second cont	5	Nould a Mer narks	2		nin (Tuna Print)		10h Mailir	n Address (Street			r City or Tow	n State Zin	Code)	
Second Avenue S.W., Glen Burnie, MD 21061   Approximate of the second contract of the second cont	10	Mal d 2 st d 2 st th and th and traur	1											
Second Avenue S.W., Glen Burnie, MD 21061   Approximate of the second contract of the second cont	0)	Heal			es wile	20b. P								
Second Avenue S.W., Glen Burnie, MD 21061   Approximate of the second contract of the second cont	-	Pages ent of nt: If i				tate			4	. 2004	Brook	Lvn. M	D	
Physician (Medical Examiner)  23a. PArt: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, content failure—Late only one causer of heart failu		mit. It partm partm poorts.		H		,								
Physician (Indecical Examining in death)  Sequentially list conditions. Sequentially list condit	9			1 1	N	01220								
Physician (Redical Examiner Property of Consequence of):    Physician (Redical Examiner Property of Consequence of):		1		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death ch fine.	. Do not ent	er the mode of dyi	ng, such as cardiac o	or respiratory ar	rest,		Interval Between	
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that inflated events are consequence of):    Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that inflated events are consequence of):				disease or condition	-a. C0	ugar	rue	He	art 1	all	ine		1 E) Carg	)11 P
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease of Incur)  OOZ ON THE PROPERTY OF THE PROPERT	_			resulting in death)	Due 10) (d	or as a consequ	ord 2	1 4 10 m	7			0	10 30	40
The final fi		· ·	-	Sequentially list conditions,	b. Due to (c	or as a consequ	-	1000	1			-	5/2/	
Second   S	1	da d	E I	cause. Enter Underlying Cause (Disease or injury	Cara	Lary	Acter	a /	meen				5 700	7
The part of the pa	~	O, exect an and rial-tra	Exa	resulting in death) Last	Due to (d	r as a consequ	uence of):	/						
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		176 Ite be nysicie	cai		d									
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		riffica	Med	IF FEMALE:							-	J.,		
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		ath ce	lan/	23b. Was decedent pregnant	1 Live bit	th 2 🗍 Fetai	death 3		y				•	r
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		D. he de che che che che che che che che che ch	ysic	1 ☐ Yes 2 ☐ No			atn 5L	Ciner (specify) _						
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		D. that the detac	, Ph	Part ff. Other significant condition	ns contributing to de	ath but not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of deat	h?
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		ds dires	d b							1 🗆 Y	es 2 (No	3 🗆 Prob	ably 4 🗆 Unki	nown
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		w req	iete								an 24t	. Were auto	osy findings ava	ilable
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		Re la le ha:	mo							perfor	med?	death?		3 OF
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		ital							26. Place of Death					
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		of V hysic his ce			1 Lin		ER/Outpatier	t 3 DOA	4 Indising no				<i>'</i> )	
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		Ing P	on:	1 X Natural 5 ☐ Pending	9	f Injury n, Day Year)		Wo	rk?	28d. Describe h	low injury occ	urred		
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		Sion trend death tor: /	icat	3 Suicide 6 Could n	not be 290 Pface	of lower . At he	mo farm etc			28f Location /S	Street and Nur	nher or Rura	I Boute Number	
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		Divi	ertif		ined 200. Flace buildin	g, etc. (Specify	()	eet, factory, office				noor or rigin	710010 11001	
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		spitel sours neral												
1 Valentice NO 041 (4BIX-MD) 1081684 102-05-2-18		n 24 h n 24 h ne Fu	edic				tion and/or in	vestigation, in my o	opinion, death occurr	ed at the time,	date and place	and due to	the cause(s)	
30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  O-V, CARIAC M-D 8021 RITCHIS OWI, PASADISNA MD 21122  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To the To the Comp	Σ	29b. Signature and title of certifier				7						
30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  O-V, C4RIAC.M-D 8021 RITCHIB CWI, PASADRNA MD 21122  State Registrar  FFR 10 2004  State  FFR 10 2004  Registrar's Signature				Majne	ew CV	. CYRI	x-40		081684		02	-05	-200 4	2
State Registrar FPR 1 0 2004 State Signature		10		30. Name and address of person	who completed cause	of death (fter	23а) Туре.	Print)	DO YUN	(ADZO)	AMI	0	2.2	
Registrar FFR 1 0 2004 Meseus & America		St	ate		32. Rg	pistrar's Signa	ture	COTICS C	1 / /		1 100	0/11	~ ~	
				FFR 1	0 2004	laeur.	B. A.	modes						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Elizabeth Rogers Mullan 7:30P M February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Blakehurst** Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 16, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Maryland 216-03-1779 89 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "netural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed by 3 ☐ Widowed 4 💢 Xivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) .. Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked ott ijury or other treumatic ever Clifton Rogers Agnes Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marylou Fineran DTR 614 Manor Drive Salisbury Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or oti XX Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 2/9/04 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility.
Mitchell-Wiedefeld Funeral Home, Inc
4500 Vork Rd Baltimore, MD 21212 nature of Funeral S 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one days on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) esnovasculan Physician Sweeks /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 22No 3 Probably 4 □Unknown 1 🗌 Yes revolentie Varilar Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s performed Yes 2 2□ No 1 ☐ Yes 1 Yes : After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire ŏ 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 6301 NCHALLES STREET BALTMORE MO 21212 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2004 Registrar

		1	For State Registrar		Marylar		artmen rtificat			and M		Reg. No.	200	er economic	03727
- 1	Physicia		<ol> <li>Decedent's Name (First, Middle, L.</li> </ol>	ast)							2. Date of Dea	Day	Ye	ar,	3. Time of Death
	/Medica	1	Imogene	М.	Mor1	ock	45-05-	T	Location o	4 Death	Herman	9.5	County of D	124	10:15A,M.
	Examine	r	4e. Fecility Name <i>(If not institution, gi</i> North Arundel Ho		Der)		40. City,		n Bur				Anne		ndel
V.	Euperel				'. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt				ace (State or Foreign
	Funeral Director			1□ M 2⊠ F	7	7 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day June 23	192	6	Counti	WV
	P.		Usual Residence of Decedent 10a, State 10b, County		10a Ci	ty, Town or Lo	antion							10	d. Inside City Limits
	e Marylar Ba-f show	ctor	Maryland Anne	Arundel	100. CI	ly, Town of Co			adena	ì					1 ☐ Yes 2 🖾 No
3	23a or 2	Funeral Director	10e. Street and Number 7721 Shirley Av	/enue			10f. Zip		2112				en of What	SA	
<i>a</i> 7 % 03€	urs a	2	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? 2 [X] No		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)		4. Race - A Black, W Specify:		tc.
170 X	within 72 ho ene. then *natur	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) Coltege (1-	4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during most )	t of work	ing	16b. Kin	d of Busine		
21	Hygien wither the	5	8				Home	make					House	ehol	<u>d</u>
GENE Maryland	d out	lo Be	17. Father's Name (First, Middle, Las Cecil P	erkins					Nir	na	e (First, Middle, Amer	rica			
Maryla	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship Carol Morlock	(Type, Print) (daughte	ar l						Pasader				Code)
_	1 and 4ealth 9rm 27 ther t		20a, Method of Disposition								_		ation - City		vn. State
2 5	0 0		1 ☑ Burial 2 ☐ Cremation 3:  '4 ☐ Donation 5 ☐ Other (Spec		tatie i	Place of Dispo cemetery, crei adownic					<sup>0a</sup> 19 04				ryland
IM 0Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Juneral Service Lice	~ ~	i ne	0.5									me, P.A.
7			23a. Part1. Enter the dit ase, or conshock, or heart failure. List only	nplications hat co	used the deal			_							Approximate Interval Between Onset and Death
68760,	ysicia	ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b. Due to (c	or as a consecutive as	quence of):	icesi an l	en							
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1  Yes 2 No 9 Unknown		nth 2 ☐ Fete ant at time of c	el death 3	]Ectopic pi ] Other (sp	,				2	3d. Date of Month		y Day Year
	uires that	ρ	Part II. Other significant conditions	contributing to de-	ath but not res	sulting in the u	nderlying o	ause give	en in Part I.			obacco us Yes 2[	X		e cause of death?
Division of Vital Records,		Completed		<u></u>									prior deat	to com	sy findings available ipletion of cause of
/ita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Till a state of				04		of Deat	h (Check only o	ne)			
of C	hys this	9	1 Tyes 2 No	( )		ER/Outpatier		1000000	4 L Nu	-	me 5 Resid			Specify)	)
u	ding Ph. After thi funeral	lon	27. Manne of Death  Natural 5 Pending		n, Day Year)	28b. Time o Injury	M	8c. Injun Work	γαι k? Yes 2.∐.I		28d. Describe I	tow injury	occurred		
Divisio	or Atten ifter deat Director: In by the	Certification:	Accident investigati  3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At h g, etc. <i>(Speci</i>	lome, farm, st ly)			.00 22		28f. Location (S City or Tox		l Number o	r Rural	Route Number,
4		Medical C	29a. Certifier (Check only one) Certifying R	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) date and	and manne place, and	r as sta	ated. the cause(s)
	within 2 To the comple	ž	29b. Signature and title of certifier				29	. License	e number		1 .		signed (M		
	1		1 人		non			) 4	397	7	1	elm	lan	5	2004
	6		30 Name and a drest of person wh	o completed cause	of death (Ite	m 23a) (Type,	Print)	,	1 1	1	. (	5.50	/	Δ.	2014
-			worn Theyw	W1 30/	#056	WEN.	1)KW		400	1 3	While	_ · N	ND	47	1911
	Stat Registra		31. Date filed (Month, Day, Year)	32. Re	agistrar's Sign	ature	doa	Kal							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February Anna Μ. 0chs 2004 4:55 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) March 22, 1917 Birthptace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 86 Director 213 10 2543 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinations for motified at Baltimore 1 ☐ Yes 2X No Anne Arundel Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S. 107 Cedar Hill Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or Ite ury or other traumatic event, the Medical Exuralm 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: þ 3 TyWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Underwriter Insurance Company 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (not available) Deems (not available) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 107 Cedar Hill Road / Daughter Baltimore, Maryland 21225 Ann Canova 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Meadowridge Mem. Park 2/6/2004 Elkridge, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway arxon Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lateri Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed annes Division of Vital Records, P.O. Box 68760, Physician/Medical use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ò in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physiclen: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funerel C
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ak D18426 PATALINGHUG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATAL Poter ST. BAITO, MD CARlos INGhUS 31. Date filed (Month, Day, Year) FEB 1 0 2004 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Рм February 2004 2:10 Panek Evelyn /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 6801 Fait Avenue ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

August 30, 1933 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months 1 ☐ M 2 💢 F 70 MD. 212-30-1771 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Modical Examinan munitual to retified at ty∏Yes 2□No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21224 6801 Fait Avenue by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Maritaf Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify. Specify: 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coffege (1-4or 5+) Food Service 12 years Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casimir Sokal Michalina Wionzcek ို 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 Fait Avenue, Baltimore, Md. 21224 Joanne Heddinger Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Sacred Heart Of Mary Cem. 11,2004 ^ 4 □ Donation 5 □ Other (Specify) Dundalk, MD. 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Pert1 Enter the disease, pricomplications that caused the disease. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervaf Between Onset and Death fmmediate Cause (Finaf pertension years Physician Monary /Medical resulting in death) Due to (or as a consequence of): **Examiner** leroderma Sc. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy tor in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 90 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No this completely filled in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After Attending 5 Pending investigation 1 Maturaf 1 ☐ Yes 2 ☐ No м death. 2 Accident 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide ö within 24 hours a To the Funeral D To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 043732 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)
Michael Harper, MD Cost Hapk. SSOS Hopkins Bayview Circle In Itimora, MD 21224 Harper, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 0 2004 Registrar

				1 - For State Registrar	State o	f Maryland /		artment of H			ene 2 (	04	03730
	W.	7 F	9	1. Decedent's Name (First, Middle	, Last)			1		2. Date of Death Month	Day	Vaca	3. Time of Death
		Physicia /Medic	_	Catherine	Teresa	Preisin	ger			February	5, 20	04	10:00A M
•		Examin	. III	4a. Facility Name (If not institution	give street and nur	mber)		4b. City, Town, or	Location of Death		4c. County	of Death	
	1			Gilchrist Cent	er			Towson			Ba1	timo	
	F	uneral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Cour	
	Di	irector		219-30-2692		69	Yrs.			Sept 27,	1934	Maı	ryland
	and	A =	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
	Mary	e pa	ō	Maryland Balt	imore	T.	Thite	Hall					1 ☐ Yes 2 No
	the	notili	Director	10e. Street and Number	.Imore		IIITEC	10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	with	38 0		17609 Troyer Ro	vad			2116	1		USA		
	deat	ms 2	ner	11. Marital Status		edent Ever in U.S.	13. \	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-	14. Ra	ce - Americ	
	after	or Ite	T	1 ☐ Never Married 2 🕅 Marri		2 ☑ No	- 1	rres, specily Cubai □ Yes 25√2 No	Specify:	nican, etc.)		ck, White,	etc.
	5-0036 72 hours after death with the Maryland	Exa	d b	3 Widowed 4 Divorced	Year or D	ates:		- X 100	opocity.		Specif	Whi	te
ì	2-C	nati	Completed by Funeral	15. Decedent (Specify only highes	's Education t grade completed)	16	a. Deced (Give	lent's Usual Occupa kind of work done d DO NOT use retired)	ition Juring most of work	ing 1	6b. Kind of B	usiness/In	dustry
	Z jigi	Le Maria	mp	Elementary/Secondary (0-12)	College (1						0	77	
	N Pilled	ther nt, p	ပ္ပ	12 17. Father's Name (First, Middle, I	n/	a	нс	memaker	18. Mother's Nam	a (First Middle M		Home	<u> </u>
	d be	o pe	Be	Salvatore	Pistori	io			Antone			Lsomi	
	Shock S	mar	၉	19a. Informant's Name/Relations			b. Mailin	g Address (Street a					
3	Ma 2 and a se	27 ls r trau		John T. Preisir	nger. Sr./	Husband	1760	9 Troyer	Road, Wh	ite Hall	. Marv	land	21161
	S 1 a	item		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place	-1	Date 2	Oc. Location		
	Page Page	ry or		1 ☑ Burial 2 ☐ Cremation  1 ☑ Burial 2 ☐ Cremation  1 ☑ Burial 2 ☐ Cremation		State	-	alley Me.	12/9/0		'imoni:	ım. Ma	aryland
	Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours att	Important: If feem 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Mudical Examinating must be notified at once.	8	21. Smalure of Funeral Service I	ichempi	1	22	Name and Addressemmon Fur	s of Facility	o of Dul	07077	01100	Too
	<b>ක</b> දීපී	E = 8		Bryan W. Cla	iry	1	1)1	0 W. Pado	onia Road	, Timoni	um, MD	210	93
				23a. Part1. Enter e isease, or shock, or heart f lure. List	complications that conly one of use on e	aus of the death. Do	not ente	er the mode of dying	, such as cardiac	or respiratory arres	st,		Approximate Interval Between
	Phy	sician		Immediate Cau a (F al disease or condition				- CA	_				Onset and Death
		ledical aminer		resulting in death)	Due to	or as a consequence							0
X	EXA	annaner		Sequentially list conditions,	b								
2/	/2	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a consequence	e of):						
100	xecut	and Il-trar	хап	that initiated events resulting in death) Last	c. Due to (	or as a consequence	e of):					-	
d	8760,	ohysician and the burial-transit	icai E										
61	687	phys	edic		d							500	
	OX h certi	attending p for use as	Ň	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy					23d. Da	te of delive	ory
1		d for	Physician/Medi	in the past 12 months?	4□Pregn	irth 2 Fetal deat ant at time of death		Ectopic pregnancy Other (specify)			Mo	onth	Day Year
3	0 8	ed by the detached	hys	9 □ Unknoyn	9□ Unkno	own							
Reisinger	ecords, P.O. Box 61 law requires that the death certific	0 0	by P	Part II. Other significant condition	ns contributing to de	eath but not resulting	j in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use con	tribute to th	ne cause of death?
10	ord Squire	been sign should be	ted							1 ☐ Yes	2 No	3 Prob	ably 4 □Unknown
27	Vital Records sicien: The law requires	2 33	Completed							24a. Was an autopsy		Were auto	psy findings available inpletion of cause of
2	F P	pag	Con							perform	ed?	death?	2□ No
	of Vita Physician:	certificate rector, pag	Be	25. Was case referred to medical examiner?						(Check only one	)		- (i -
3	P Pysi	this c al dire	2	1 ☐ Yes 2 No	-	npatient 2 ER/C			4   Nuising no	me 5 Residen			Hosters
=		After	jo	27. Manner of Death  1 Natural 5 □ Pending	9	of Injury 28b. th, Day Year)	. Time of Injury	28c. Injury Work		28d. Describe hov	njury occur	red	
छे :	/ISION Attending	the the	icat	2 Accident investig 3 Suicide 6 Could r	not be	of Injury - At home,	farm etre		′es 2 □No	28f. Location (Stre	et and Numb	Ar Or Dura	I Boute Number
CHIBNIN	= 5 9	Director:	Certification:	4 ☐ Homicide determ		ng, etc. (Specify)	iaiii, siit	ser, ractory, onlos		City or Town,		or or ribia	Thouse Number,
3	Hospital of 24 hours at	To the Funeral Director: After this certific completely filled in by the funeral director.	alC	29a. Certifier 1/2 Certifyin	g Physician: To the	best of my knowledg	ge, death	occurred at the tim	e, date and place,	and due to the cau	use(s) and ma	anner as st	ated.
	ne Ho	ne Fu	edical	(Check only one)	Examiner: On the base and man	asis of examination a ner stated.	and/or inv	estigation, in my op	inion, death occurr	ed at the time, dat	e and place,	and due to	the cause(s)
	To the within 2	Tot	Σ	29b. Signature and title of certifier	N	1.1.	1	29c. License		29	d. Date signe	d (Month, I	Day, Year)
	,	6		1 40 pm	almy 1	July V	رفاس	12	2902	FE	610 A	75	,2004
	1			30. Name and address of person			(Type, I	Print) Cha	les C2	B. O.	n - m -	121	206
	1/			31. Date filed (Month, Day, Year)				N. Cra	37,	Vact	7.00		
		Sta Registr		FEB 1 0 2004	32. 4	egistrar's Signature	mode.	Þ					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 4, PHILLIPS 2004 3:20 P ANNA ROSE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILLERSVILLE KNOLLWOOD MANOR NURSING HOME ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) 10/5/1923 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) 5. Sociat Security Number 6. Sex **Funeral** 1 M 2)(C)(E Months FLORIDA 80 Director 263-24-7572 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23e or 28a-f ehow any injury or other traumatic event, the Medical Examinations to notified at once. 10a. State 10b. County 1 Tyes 2X No ANNE ARUNDEL GLEN BURNIE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code USA 21061 533 CRESTPARK DRIVE Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3€Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL INSPECTOR MARTIN AIRCRAFT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 533 CRESTPARK DRIVE, GLEN BURNIE, MD 21061 ROBERT EARL PHILLIPS, JR. - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State LOUDON PARK CEMETERY 2/9/2004 BLATIMORE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 KELLY GREGOR #M01148 FINK ter the diseal, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, learn failure. List only the cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Exter the diseas shock, o leart failure. I tmmediate Cause (Finat PNEUMONIA WEEK **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicia Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat de 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetat death Year ò in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No page perform 1 ☐ Yes 2 ☐ No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Yeer) 28d. Describe how injury occurred After Hospital or Attending Injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 1)31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD, NOTTINGHAM, MW 21236 ACE, M) 9005 WALL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 0 2004 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		-		partment of Health and M ertificate of Death	ental Hygier	- / U1114	03732
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		John Engel Pfeffe	r	February	6, 2004	09:30 A M
	/Medic Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	LAAITIII	-1	201 Buckingham Drive	Glen Burnie		Anne Aru	nde l
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Ye Dec 20, ]		hplace (State or Foreign
	Director		218-09-3839 1 M 2 F 83 Yrs	Months Days 1100.0	Dec 20, 1	1920	MD MD
	p .		Usual Residence of Decedent         10c. City, Town or           10a, State         10b, County         10c. City, Town or	Location			10d. Inside City Limits
	anyla ehov	5	MD Anne Arundel Glen Bu				1 ☐ Yes 2 ☑ No
	he M	Director	10e. Street and Number	10f. Zip Code	100.	Citizen of What Co	puntry?
	with a or i	늅		21061		USA	
	ns 23	Funeral	201 Buckingham Drive  11. Marital Status  12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
	r iten	ᆵ	1 Never Married 2 Married 1/19/49, Give 3 Q 4 5		Rican, etc.)	Black, Whit	
980	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 39–45	1 ☐ Yes 21 No Specify:		Specify: Wh	ite
9-0	72 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	ng 16b	. Kind of Business	Industry
21	ithin ee.	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	a. DO NOT use retired)		A T D	
2	ygien ygien ygien th	Co		IS Driver	(First, Middle, Maid	MTA	
ם	be fill	Be	17. Father's Name (First, Middle, Last)  Richard J. Pfeffer	Mary Enge		ien Sumame)	
2	should be filed within 72 hours after death with the Maryland nd Mental Hygiene.  In Merked other than "natural", or items 23e or 28e-f show umatic event, the Medical Exercities mail be notified at	ို		ailing Address (Street and Number or Rura		ty or Town State	Zin Code)
Mai	d 2 st th and 7 le r traur			Buckingham Drive			21061
oʻ	s 1 and 2 of Health a Item 27 le other trau		20a Method of Disposition 20b, Place of Di	sposition (Name of	Date 20c	. Location - City or	
ē	Pages nent of I int: If Its iry or o		1 DRurial 2 I Cremation 3 I Hemoval from State	rematory of other place) Feb 1 1 Veterans 2004	LO	rownsvill	e MD
Baltimore, Maryland 21215-0036	그 든 뿐 중		21. Signature of Funeral Service Licersee	7.004	ngleton Fu		
Ba	Depar Impo		MANUSILLA MOISEY	Second Avenue SW			21061
			23a. Part1. Enter the disease, or complications that caused the death. Co not shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
	Physician		Immediate Cause (Final	Course Min	tastat	u)	Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	Cavicac / rue	N-EU) ( UC		
- 1	Examiner		Sequentially that conditions by COPD U	wth Librans			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
1	ate be executed by sician and the burial-transit	Examlner	that initiated events	<u>,                                      </u>			
000	oe execian sourial		resulting in death) Last Due to (or as a consequence of):				
Box 68760	physical by the b	Physician/Medical	d				
× 6	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	ivery
Bo	eath certific attending p	cian	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	the d	ıysi	1 Yes 2 No 9 Unknown				
0	res that the de signed by the a I be detached f		Part II, Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
rds	quires n sign	d by			1 ☐ Yes	2 □ No 3 □ Pi	obably 4 Hunknown
000	w require s been si should?	Completed			24a. Was an	24b. Were at	utopsy findings available completion of cause of
Re	fhe lav te has age 2	omp			autopsy performed 1 ☐ Yes 2 🕏	? death?	2 No
ta	sician: The la certificate ha irector, page 3	a)	25. Was case referred to medical	26. Place of Death	(Check only one)	100	
<u> </u>	ysician: nis certifica director, j	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpa	tient 3□ DOA Other: 4 1 Nursing Ho	me 5 Residence	e 6 □Other (Spe	cify)
Division of Vital Records,	or Attending Physician: The law requires that the death certifica titer death. Diractor: After this certificate has been signed by the attending ph in by the funeral director, page 2 should be detached for use as the		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 1 Natural 5 Pending (Month, Day Year) Injury 1 Natural 1 Nat		28d. Describe how i	njury occurred	
Ö	Attendir death. ctor: Af y the fu	atle	2 Accident investigation	M 1 □ Yes 2 □ No			
<u>X</u>	or Att ter de iract	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stree: City or Town, S	t and Number or Ri tate)	ural Route Number,
۵	urs af	O				()	
	To the Hospital or Attend within 24 hours after death To the Funeral Diractor. completely filled in by the	edical	29a. Certifier  1 ☐ Certifying Physician: To the best of my knowledge, d (Check only one)  1 ☐ Medical Examiner: On the basis of examination and/c and manner stated.				
	o the	Mec	29b. Signature and title of certifier Chimene	29c. License number	29g.	Date signed (Mont	h, Day, Year)
	To To Cor		I have the Liburg	2 154020	1	Bruss	192004
	177		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	1	nary	17004 21061
			300 Hostnital Dune	Juste 215	Hens	Burn	214) 21061
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	1		
×	Registi	rar ,	FEB 1 0 2004 Deserve 15	grants			

			Tease  1 - For Stete Ragistrar	State of Maryl	and / Depa	artment of Healt artificate of Dea	th and Me	ntal Hygie	3	03739
-	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last FRANCIS XAVIER     4a. Facility Name (If not institution, give	POWERS		4b. City, Town, or Locat	Fe	Date of Death Month Druary	Day Year 5, 2004	3. Time of Death 9:20A M
	Funeral Director		Genesis Loch Raven 5. Social Security Number 219-22-1454  X	x 7. Age (In y	rs. last birthday) Yrs.	Parkville   If Under 1 Year   If Under 1 Year   If Under 1 Hou	ndor 04 Hrs. T.	Date of Birth (Month, Day, Y Ptember 2	Baltimor 9. Birtho 20 Pari 1, 1927 Mar	Ce place (State or Foreign cryl and
	he Maryland 8a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo		City, Town or Lo	е			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with the sale or 2	erai Dire	10e. Street and Number 8720 Emge Road	12. Was Decedent Ever in	11.6	10f. Zip Code 21234	0-1-1-2 (01		USA	
9600	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Examinar must be notified at	d by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces? XXXYes 2 □ No W If Yes, Give Year or Dates:	WII '	Was Decedent of Hispanic f Yes, specify Cuban, Mex I ☐ Yes XX No Spec		y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh	
Baltimore, Maryland 21215-0036	od within 72 t giene. er then "net	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occupation kind of work done during i DO NOT use retired)	most of working	160	b. Kind of Business/Ind Hotel	lustry
ryland	should be filed nd Mental Hygid marked other umatic event, It	To Be	17. Father's Name (First, Middle, Last) Joseph Francis Pot 19a. Informant's Name/Relationship (T)			18. M	Helena M	lartin		Codel
ore, Ma	d 2 : th ar 7 is trau		Joseph F Powers Jr  20a. Method of Disposition  1 XXeurial 2 Cremation 3 DF	Brot	her 714	Shelly Road		, Maryl	and 21286 c. Location - City or To	
Baltim	permit. Pages 1 an Department of Heall Important: If item 2 any injury or other once.		4 Donation 5 □ Other (Specify) 21 Inature of Funeral S. Nige Licens	G	arrison	Forest VA Name and Address of Fa	2/10/0 acility Mitche O York Ro	ell-Wiede	ings Mills feld Funeral ore, Maryland	. Maryland Home Inc. 1 21212
1	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	aDue to (or as a cons	an le	er the mode of dying, such				Approximate Interval Between Onset and Death
9760,	icate be executed physician and s the burial-transit	licai Examiner	Sequentially list conditions, Tany leading to in-mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons  d.	(DC-10, T					
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ry Day Year
	w requires that been signed b should be deta	ed by Pr	Part II. Other significant conditions con		esulting in the ur	derlying cause given in Pa	art I.		co use contribute to the	e cause of death?
Vital Records,	n: The law r ficate has be or, page 2 shu		OF Was and referred to medical					24a. Was an autopsy performed 1 Yes 2 🗓	prior to com	isy findings available ipletion of cause of MD No
Division of Vit	To the Hospital or Attending Physician: The law within 24 hours after death.  To tha Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	0.1	28d.	The state of the s	6 □Other (Specify,	
Divis	ital or Atte rs after det al Directo led in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	city)		×	City or Town, Si		
	the Hosp hin 24 hou tha Funei npletely fil	Medicai	one)	sician: To the best of my kiner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	estigation, in my opinion, o	death occurred a	t the time, date	and place, and due to	the cause(s)
	2 1 2 3		29b. Signature and title of certifier  MANTA NAY	rundo, m	D	DSUSTY			Date signed (Month, D	
	Y		30. Name and address of person who com  MANTHA LAMM (NDC)  31. Date filed (Month, Day, Year)	mpleted cause of death (It  MD 5601 k00  32. Registrar's Sig	A Raicon	Print) BVCL Baltimal	MD 2123	37		
	Sta Registr	_	EFR 1 0 2004	A A A	1 August	les .				

			State of Maryland / Department of Health and M  Certificate of Death		Reg. No.	03734
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Year	3. Time of Death 4 7:30 P.M.
	/Medic		John Franklin Pitcock, Sr.	03	0000	1
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  CONDINE CONTROL HOSPINE		Baltin	OOVE
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt		rthplace (State or Foreign
	Funeral Director		213-18-6992 1 M 2 F 83 Yrs. Months Days Hours Min.	April April	<sup>th</sup> year) 9.8 15,1920 Ma	ryland
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	shov	ō				1 □ Yes 2 ☑ No
	28a-f	ect	Maryland Baltimore Parkville  10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	
	ath with the Marylan 23a or 28a-f show		8820 Walther Blvd., Apt. 3104 21234		U.S.	١.
( •	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No	- 14. Race - An Black, Wh	
5 8	or Ite	y Fu	1 □ Never Married 2 💢 Married 1 💢 Yes 2 □ No If Yes Give (IIII 7.7 1 □ Yes 2 🖼 No Specify:	, ,	Specify: W	
600	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fra Medical Exercitiva mast ke motified at	q pa	3 Wildowed 4 Divorced Year or Dates: WW 11  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	
不可	in 72 in 72	plete	(Specify only highest grade completed) (Give kind of work done during most of work) life. DO NOT use retired)	ing	TOD. TRITE OF BUSINESS	amaday
212	TI (0) 2	E O	Elementary/Secondary (0·12) College (1·4or 5+) 2 Salesman		Trucking	
P	be filed tal Hygir d other event, I	To Be Completed by Funeral Director			, Maiden Sumame)	
y Ja		L <sub>O</sub>	Charles E. Pitcock, Sr. Margar		owell	7-0-4-1
Mar	12 sho h and 7 ls m traum	î Î	19a. Informant's Name/Relationship (Type, Print)  Ms. Barbara Ann Pitcock (dghtr)  19b. Mailing Address (Street and Number or Rura 4105 Pinedale Drive,			1236
<u>©</u> ó	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	Ì		Date	20c. Location - City	
	00			/2004	Baltimore,	Maruland
alti a	permit. Page Department of Important: If any injury of once.		21. Sign for all Fune at Service Licens 22. Name and Address of Facility Chic			
ű.	Depa Impo any it	1 0	9705 Belair Rd., E	Baltimo)	re, MD 21:	236
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	1 .	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a.   ACUTE CEREBRA INTARC	71011		J
11/2	/Medical Examiner		Due to (or as a consequence of):			
X W		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
00	be executed sicien and burial-transit	Examiner	Sequentially list curuations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
o,	en an		resulting in death) Last Due to (or as a consequence of):			
8760,	ate be hysici the bu	ficai	d			
Box 68	leath certifica attending ph I for use as tt	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Date of d	olivone
Bo	attender for us	clan	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of d Month	Day Year
P.O.	t the de by the a	nysi	1 Yes 2 No 9 Unknown			
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be deteched for use as the burial-transit	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ıds	w require been sig should b	led b		1 🗆 '	Yes 2 XNo 3□	Probably 4 🗀 Unknown
ecc	e law re has be je 2 sh	ompieted		24a. Was autor	psy prior to	autopsy findings available completion of cause of
E R	ysician: The lis certificate hadrector, page	Con		1 Yes	ormed? death' 2XNo 1 ☐ Yo	
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:			
jo	Phys this ral dir	5	1 Inpatient 2 A EH/Outpatient 3 DOA 4 Nursing Ho		dence 6 Other (Sp how injury occurred	pecify)
o	ding F th. After funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No		,	
Division of Vital Records,	or Atten ifter deat Diractor: in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Hornicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (	Street and Number or .	Rural Route Number,
D	tal or	Cert	Sullulity, etc. (Specify)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only (Ch	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	thin 2 tha tha mplet	Med	one) and manner stated.  29b. Signature and title of peritter / 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	7 × 7 8		) (/al//LUD D55885		2/5/04	
1	11		30-Name and address it erspn, who impleted cause of death (Item 23a) (Type, Print)	7 11 .	- / M	1 21227
4	6 ,		30 Name and address to erspn who completed cause of death (Item 23a) (Type, Print)  Dr. Jack Ko 9000 Franklin Square Drive. I	Saltin	more, 111	1.01931
	St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature			

ORIGINAL

			For State Registrar	State of Maryl	•	artment of H		Re	g. No. 2004	03735
1	Physicia	an	1. Decedent's Name (First, Middle, Last)	Kathleen	Robin	agon		2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic				KODII		Landing of Dag	Feb.	8 2004 4c. County of Deet	5:50 A M
	Examin	er	4a. Fecility Name (If not institution, give s Riverview Nurs		r	4b. City, Town, or Essex		ıtrı	Baltimo	
	E		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth	O Riet	nplace (State or Foreign untry)
c	Funeral Director			M 2√2 F	52 Yrs.	Months Days	Hours Mir	Nov. 2,	1951 Mar	yland
	P _		Usual Residence of Decedent	140-	. City, Town or Lo					10d. Inside City Limits
	arylar show	5	MD Balti		**	Essex				1 ☐ Yes Ş⊕ No
	he M	ecto	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
	with with the control	Funeral Director	1121 Tace Driv	e		2122	1		USA	,
	ns 23	era		2. Was Decedent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	14. Race - Ame	
ထ	or Real	귤	1 Never Married 2 Married	Armed Forces?	i i	iryes, specify Cuba 1 □ Yes 2 🕱 No	n, Mexican, Pue Specify:	rto Hican, etc.)	Black, White	
ğ	rel', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TO THE ZIZINO	эрвспу.		SpecifyWhi	te
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Maryland to Maryland.	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of w	orking	6b. Kind of Business/l	ndustry
12	within ane. than	di	Elementary/Secondary (0-12)	College (1-4or 5+)		ld Care	,		Day Care	
	Hygie Hygie offher ant, u		12th 17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M		
an	Mental Mental arked c	To Be	James Marchant				Helen	Asch		
Maryland	should and Men a marke umatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street	and Number or f	Rural Route Number,	City or Town, State, Z	ip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event, if a Medical Examera must be notified at		Helen Marchant/				e Road	-	re MD 21	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	amoval from State		matory or other plac		1. 1.01	Oc. Location - City or	
Ĕ	Pag ment tent: jury c		*4 ☐ Donation 5 ☐ Other (Specify)			w Cremat	1	1	Baltimore	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Funeral Service License	Conne	lly 2	2. Name and Addres	ss of Facility Co	onnellyF . Baltim	uneralHomore MD 21	meofEssex
	Physician /Medical Examiner prival-Itausit prival-Itausit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	isequance of).	e Liv	ver I	)I sea se		Onset and Death
ς 68760,	# × #	cal	IE EEMALE:		-2001					
.O. Box	of the death certifica by the attending phace tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. ff yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of defi Month	very Day Year
ds, P	uires the	Ď	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	inderlying cause give	en in Part I.		accoluse contribute to s 2 □ No 3 □ Pro	the cause of death? obably 4 ⊡Unknown
of Vital Records,	The law requires thet the rate has been signed by the page 2 should be detache	Completed				·- <del>-</del>		24a. Was ar autopsy perform 1 Yes 2	24b. Were au prior to c death?	topsy findings available completion of cause of
Ita	Physicien: This certifical ral director, p	Bec	25. Was case referred to medical examiner?					eath (Check only one		
× <	Physic this ce al dire	P	1 ☐ Yes 2 ☐ No		2 ER/Outpatie		4 Lowersing		nce 6 Other (Spec	cify)
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Worl		28d. Describe ho	w injury occurred	
Division	Atten deat octor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury -	At home, farm, st		Yes 2 □ No		eet and Number or Ru	ral Route Number,
á	s after al Director	Cert	4   Horricide	building, etc. (S	oecny)			City or Town	, State)	
	To the Hospitel or within 24 hours after To the Funerel Directory completely filled in b	Medical		nician: To the best of my ner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o	pinion, death oc	curred at the time, da	te and place, and due	to the cause(s)
	To the I within 2 To the Complet	M	29b. Signature and title of certifier	) in ? =		29c. Licens	e number	29	3d. Date signed (Month 2/9/00 3GLH*ma	n, Day, Year)
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print)	4		2 .	21221
_	1		TARIQ MAUN	1000 201-	109 B	ackRiv	er Nec	kna 1	Saltima	ire MO
	Sta		31. Date filed (Month, Day, Year).	32. Registrar's	ignature					
	Regist		FEB 1	0 2004	eques d	" Apole	5			
DF	HMH 17 Rev 1/2	:001		d <sup>a</sup>		25				

₹T.	ROBINS	ON		State of Maryland				_	_	
			= For State RegistrarAMEND ITEM #20a						g. No. 2004	03736
			Decedent's Name (First, Middle, Last)	<u> </u>	137010.	•		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Earl Robin	nson S	r.			FEB. 6	, 2004	11:30 A <sup>M</sup>
	Examin	1	4e. Facility Name (If not institution, give s				Location of Death ORE CITY		4c. County of Death	1
609			925 NORTH BROADWA  5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birtl	nplace (State or Foreign
	Funeral Director			M 20F 65	Yrs.	Months Days	Hours Min.	Sept. 3	1938 MG	(Vand
	g		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	ation		1		10d. Inside City Limits
	Aaryla Pehov	ö	Mass dand A/A	I	2014	MACO				1 Yes 2 No
	28e-	rect	10e. Street and Number		Apt.	10f. Zip Code		10	g. Citizen of What Co	untty?
	death with the Maryland ms 23a or 28e-f ehow	ai Di	925 N. Brod	dway St.	409	212	205		115	H
	tems terms	Funeral Director	The trial desired	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	I', or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1	☐Yes 2 No	Specify:		Specify: D	Inck
ခု ဂ	within 72 hours after ene. then "naturel", or ite ne Medical Examine	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Decede	ent's Usual Occupa	ation furing most of work )	ina 1	6b. Kind of Business/	Industry
21	hen hen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. D	) 1	)		Tan	House
7			17. Father's Name (First, Middle, Last)			orter	18. Mother's Name	e (First, Middle, M	aiden Sumame)	TOUSE
Maryland 21215-0036	should be tiled within nd Mental Hygiene imarked other than unatic event, tra M	To Be	HACURY RO.	hinson			Marth	1a Ba	nKs Re	phinson.
ary	2 should and M la mail	_	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing	Address (Street a	and Number or Run	al Route Number,	City or Town, State, 2	(ip Code)
	and and mostly mark		MS. Sharon +	robinson	824 Tace of Dispos	N. Str	eeper:	ST. Bate 2	LITO, NA Oc. Location - City or	21205
סב	nit. Pages 1 and 2 should artment of Health and Men ortant: if Item 27 is marke injury or other traumatic.		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ R	emoval from State	emetery, crem	atory or other plac		languil	DUNDALK, MD	TOWN, State
altimore,	nit. Parame artme ortani injury		. 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		. CARMEL	Name and Addres	is of Facility		DOTALIZAÇÃO	tent.
ä	permit. Departr Importa eny inji		Joseph	L. Kuss	1 22	Seph. h	· KUSSA	tunera	to Man 2	1216
			23a. Part 1. Enter the are ease, or complied to the complete state of the complete state	cations that cabled the death e cause on each line.	h. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
E	Physician		Immediate Cause (Final disease or condition resulting in death)	Arterioscler						Oliset and Deali
Н	/Medical Examiner		Tesuming in death)	Due to (or as a consequ	uence of):					
Į.	3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as a sonsequ	uance of);					
	cuted nd transit	Examiner	that initiated events							
760,	ie be executed ysician and e burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequ	uence of):					
687	w ~ w								100	- 10.0000
Вох	leath certificate attending phy I for use as the	M/UE	23b. was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23d. Date of deli	
O. B	e deat	by Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)			Month	Day Year
٥.	w requires that the de been signed by the should be detached	Phy	Part II. Other significant conditions cor	tributing to death but not resi	ulting in the un	deriving cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	uires l signe ld be	d by		,				1 ☐ Yes	s 2 ⊠No 3 □ Pr	obably 4 Unknown
00	as beer 2 shou	ojete						24a. Was an		topsy findings available completion of cause of
æ	The lavate has	Completed						autopsy perform	ed? death?	2 No
/ita	cian: entifica ector,	Be	25. Was case referred to medical examiner?			0.4		h (Check only one		
<del>_</del>	Physi this c	2	1 X Yes 2 No  27. Manner of Death		ER/Outpatient 28b. Time of		4 🗆 Nursing Ho	ome 5 Resider	nce 6 Sther (Spec	city) AT SCENE
O	ding th. : After s tune	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ No		,,	
Division of Vital Records,	r Attendi er death. rector: A by the tu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
٥	Hospitel or Attending Physician: The law requires that the death certificat 24 hours after death. Funeral Director: After this certificate has been signed by the attending phy telegral Director. After this certificate has been signed by the attending phy telegraphy the funeral director, page 2 should be detached for use as the telegraphy of the funeral director.									
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely tilled in by the tuneral director, page	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Monti	
			Icasha I the	enhere 1	40	0.0	.M.E	F	EB. 6, 20	<i>/</i> U4
	S		30. Name and address of person who co				Pal+imos	na Marari	and 21201	
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar's Signa		sueel,	ратсшю	re, naryı	CIGUI	
	Regist		FFR 1 0 2004	Gentra		oaks				
		001	1 th 1 0 con-		11					

ORIGINAL

				1 = For State Registrar	State of	Marylan		artment <i>tificate</i>		ealth and I Death	-	giene Reg. No.	2004	03737
				Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
		Physic /Medi		William Everet	t Ridgley						Februar	ul 5	2004	11:20 PM
		Examir		4a. Fecility Neme (If not institution,	give street and num	ber)		4b. City, T	own, or	Location of Death		Z1	County of Deeth	
	4			St. Agnes Heal	thcare			Bal		ore				
	я	Funeral		9.	6. Sex 7 1⊠M 2□F	. Age (In yrs.		If Under 1 Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct 25	th y, Year)	9. Birth	place (State or Foreign intry)
		Director		212-10-5492 Usual Residence of Decedent		86	Yrs.				Oct 25	, 19	17 Mar	yland
		land		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
		should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other than "natural", or Itams 23a or 28a-f show unatic event, i'ra Medical Exam at must be mullied at	ğ	Maryland Balti	more		Baltim	ore						1 ☐ Yes 2X No
		7.28s	Director	10e. Street and Number				10f. Zip 0	Code			10g. Citiz	en of What Cou	intry?
		h with	E C	927 St. Agnes	Lane			2	1207	7		U.	S.A.	
		deat	Funeral	11. Marital Status	12, Was Deced	lent Ever in U.		Vas Decede	ent of Hi	spanic Origin? (S n, Mexican, Puert	pecify Yes or No	- 1	4. Race - Amer	
	9	after or Itu	臣	1 ☐ Never Married 2 ☑ Marrie	d 1 GYes 2 If Yes Give	□No 194	3-	Yes 2		Specify:	o riican, etc.)		Black, White	, etc.
	8	ural',	d by	3 Widowed 4 Divorced	Year or Dat	les: 1945							Specify: Wh	ite
	21215-0036	*nati	Completed	15. Decedent's (Specify only highest	s Education grade completed)		16a. Deced	ent's Usual kind of work	Occupa done d	ition furing most of wor )	king	16b. Kin	d of Business/fr	ndustry
	12	withir ane. Ithan	E D	Elementary/Secondary (0-12)	College (1-4	4or 5+)			e retirea)	)		D1	. 1	
	d 2	Hygie ther ont,		17. Father's Name (First, Middle, L	ast)		Plum	ber_		18. Mother's Nam	ne (First Middle		nbing	- 4.
	an	d be ental	o Be	George W. Ridg						Emma Sma		iviaidoi? c	ourname)	
	Maryland	shoul nd Me mark	은	19a. Informant's Name/Relationshi			19b. Mailin	a Address (		nd Number or Ru		er. City or	Town State Zi	n Codel
				Elizabeth D. Ric		lfe)	1			Lane Bal				
	Baltimore,	8 E B		20a. Method of Disposition		20b. P	lace of Disposemetery, crem				Date		ation - City or T	
	e E	Pages ent of nt: If I		1 ☑ Burial 2 ☐ Cremation : 1 ☑ Donation 5 ☐ Other (Sp.		ate	emetery, crem odlawn			ł.	1 2007	77 - 1	1	2007
	Ħ	permit. Pages 1 Department of F Important: If Ite any injury or ot		21. Signature of Funeral Service		WOC	20 Lawii	Name and	Address	s of Facility	1-2004	DOOM	lawn, M	aryland
	ñ	Den Perro	١.,	Deman	Talys	edat.	7 Wi	tzke 1 30 Edi	Fune	s of Facility eral Home son Aver	of Cat	onsv	ille, Ir	nc. 21228
				23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cau	sed the death	. Do not ente	or the mode	of dying	, such as cardiac	or respiratory ar	rest,	Lie, Fib	Approximate
		Pnysician		Immediate Cause (Final	nly one cause on eac	on line.								Interval Between Opset and Death
		/Medical		disease or condition resulting in death)	a. Due to (or	r as a consequ	uence of):						-	rears
		Examiner												
		ESTABLES.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consequ	uence of):							
		be executed sician and buriat-transit	Examiner	that initiated events	с									
	oʻ	e exe ian ai irial-1		resulting in death) Last	Due to (or	r as a consequ	ience of):							
	8760,	cate be executed physician and the burial-transit	dlcai	3	d									
	9		Med	IF FEMALE:										
	P.O. Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregnal		Ectopic preg	gnancy			23	3d. Date of delive	,
	0.	the ar	Sici	1 Yes 2 No	4□Pregnar 9□ Unknow	ntattime of de m	eath 5	Other (spec	city)				Month	Day Year
	<u>o</u> .	that the de ed by the detached	Phy	Part II. Other significant condition		Ab b		4. 4. 4			an- Pidu			
	Š,	ires ti signe t be c	by	A .	11 1		liting in the un	derlying cau	nse giver	n in Part I.				he cause of death?
الما	0.0	v requir been s should	etec	Congestive	Heart Fai	1ure		-			101	′es 2□		pably 4 20nknown
$\subseteq$	of Vital Records,	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	Completed	Renal Fa	ilure		-				24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
. S	<u> </u>	iù 🟎									perfor 1 ☐ Yes	med? 2 No	death? 1 ☐ Yes	2 DNo
=	Vita	tending Physicien: The lav Beath. tor: After this certificate has the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				3	26. Place of Deal	h (Check only o	ne)		
3	of	Phys this al dir	_T	1 ☐ Yes 2 Ø No 27. Manner of Death	1 UInp	- T	R/Outpatient		-	4 🗆 Nursing Ho	ome 5 Resid			y)
-			lo	1 Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	M 280	Work?	?	28d. Describe h	ow injury	occurred	
3	vision		Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 390 Place of	flaium. At ho	farm stee			es 2 □ No	29f Location /S	'ero = e = = =	Number of G	10
5	2	or Atten after deat Director: in by the	ertif	4 Homicide determin	ed building	Injury - At ho , etc. <i>(Specify</i>	me, rarm, stre	et, ractory, c	οπισθ		City or Tow	n, State)	Number or Hura	il Route Number,
Ridgley, William	_	spital ours heral filled		29a. Certifier 15-Certifying	Physician: To the b	est of my know	vledne death	occurred at	the time	date and place	and due to the	Parien/-1 -	nd manner	Pated
4	3/	9 t 4 j	Medical	(Check only 2 Medical E.	caminer: On the bas and manne	is of examinat	ion and/or inv	estigation, in	n my opi	nion, death occur	red at the time, o	ause(s) a late and p	lace, and due to	tated. the cause(s)
_	B	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	10			29c. l	License	number	2	29d. Date	signed (Month,	Day, Year)
		->-0		> mst	4-5/	/	up	0	000	152217			_	
		h	1	30. Name and address of person w	ho completed cause	of death (Item	23a) (Type 5	Print)		, , , , , , ,		COM	rasy 6	2001
				Michella H	enggeler	90		Son t	AV	053312 enue, -	Baltimor	e,	MO 2	1229
		Sta	te	31. Date filed (Month Day Year)		istrar's Signat		P 46						•
		Registr	ar	reb 10	2004	Michelle .	D' A	1865C)						

			For State Registrar	State of Ma	ryland				ealth a		Re	g. No.		00738
	Physici	an	1. Decedent's Name (First, Middle, La	,							2. Date of Deatl Month	Day	Year	3. Time of Death
	/Medic	al	DORIS JEAN RING				41- 63-	T			'EBRUAR'		2004	8:00AM
	Examin	er	4a. Facility Name (If not institution, giv						Location of BURNIE				unty of Death NE ARU	
	Euparal		543 NOLFIELD DI 5. Social Security Number 6. S		(In yrs. las	st birthday)		r 1 Year	If Under 2		B. Date of Birth (Month, Day,			place (State or Foreign intry)
1	Funeral Director			□ M 2 <b>X</b> XF	73	Yrs.	Months	Days	Hours	Min.	Month, Day, 25/193	Year) 30	OHI	intry) O
7	2		Usual Residence of Decedent											
	ehow de	_	MD ANNE A	ARUNDEL	, ,	Town or Lo		E						10d. Inside City Limits 1 Yes X2 No
7	28e-f	Director	10e. Street and Number	Intelled								On Citizen	of What Cou	
4	10 m	늅	543 NOLFIELD DR	IVE			101. 2	ip Code 210	61			-	S.A.	muy:
4	nearr ne 23	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Was Dece			in? (Speci	ify Yes or No- ican, etc.)		Race - Ameri	ican Indian,
9	or Ita	Ē	1 ☐ Never Married XX Married	Armed Forces?	0					Puerto Ri	ican, etc.)		Black, White	, etc. HITE
5-0036	rai. c	1 by	3 Widowed 4 Divorced	1 □ Yes 2001N If Yes, Give Year or Dates:			1 🗆 Yes	2LA.No	Specify:			Sp	ecify: W	111111111111111111111111111111111111111
2	fled winn /z nours after dean win the maryland Hygiene. ther then "natural", or Iteme 23a or 28e-f ehow ent, the Myd cal Examiner over be notified at	Completed	15. Decedent's E (Specify only highest gra			16a. Deced (Give	kind of w	ork done d	durina most	of working	7	16b. Kind	of Business/Ir	ndustry
2121	1 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	ш	Elementary/Secondary (0-12)	College (1-4or 5-	+)	HOME!		use retired	)				OWN HO	MF
2	Hygie ther nt.	ပိ	12 17. Father's Name (First, Middle, Last	)		HOPILS	TAICE		18. Mother	's Name (	First, Middle, N			1111
<u>a</u>	d De ental ked o	To Be	FREDERICK EARL	O'NEAL							ELSIE I			
Maryland	and M mar		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addres	s (Street a	and Number	or Rural I	Route Number,	City or To	wn, State, Zi	p Code)
Ž i	is 1 and 2 of Health a litem 27 le other trau		WILLIAM J. RING	- HUSBAND		543	NOLF	LELD	DRIVE	, GLE	EN BURN	IE, M	D 2106	1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the marylatic Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other then "natural; or Itame 23a or 28e-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition  ABurial 2 Cremation 3	Removal from State	20b. Plac	ce of Disponetery, crer	sition (Na natory or	ime of other place	θ)	Da	te 2	20c. Locati	on - City or T	own, State
<u>Ĕ</u>	Pages ment of 1 ant: If its ury or o		'4 □Donation 5 □ Other (Special		ARL	INGTO:	N NA	r. CE	M. 2	/11/2	2004	ARLIN	GTON,	VA
alt alt	Depart Depart Import eny inj once.		21. Signature of Funeral Service Lice		)						K FUNE		-	
ш	40 E 9 9		KELLY GKEGOK	1							, GLEN		IE, MD	
	nysician /Medical		23a. Part1. Enter the disease, or conshock, or near failure. List only Immediate Cause (Final disease or condition resulting in death)	, a <i>C</i> e	NGE	STIVE		CA C	g, such as c	ardiac or	respiratory arre	ist,	Long	Approximate Interval Between Onset and Death
2 00	Examiner			Due to (or as a	SOL57	**	ALD	DUYI	mpart He	,		1	11	
	a lately	e.	Sequentially list conditions. If any, leading to immediate	b. Due to (or as a	-		,,,,,		1	_		$\leftarrow$	1/	
0	cuted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. C	1	>							P.	
9.	e exercien ar	EX	resulting in death) Last	Due to (or as a	conseque	nce of):						1		
8760	icate be executed physicien and s the burial-transit	dicai		d										
.O. Box 6	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at 1 9 ☐ Unknown	2 ☐ Fetal d	léath 3 🗆	Ectopic i	pregnancy				23d.	Date of deliv Month	rery Day Year
Records, P	ures that the de signed by the a d be detached f	þ	Part II. Other significant conditions	contributing to death bu	t not result	ing in the u	nderlying	cause give	en in Part I.			acco use		the cause of death?
Š	w require been si	Completed									24a. Was ar	2	1b Were aut	opsy findings available
Be.	he lav	щ									autops perform	V	prior to co	ompletion of cause of
E	ificate or. pa	C	25. Was case referred to medical						OF Place	of Dooth (		· · · · · · · · · · · · · · · · · · ·	1 🗆 Yes	2)XN0
>	Physician: r this certific ral director.	0 8	examiner?	Hospital: 1 ☐ Inpatier	nt 2∏FI	B/Outpatier	nt 3 🗆 🗅	OA Othe	ar.	sing Home	Check only one  5 ₩ Reside		Other (Speci	(Az)
0	g Phy erthi eral d	n: T	27. Manner of Death	28a. Date of Injur (Month, Day		8b. Time of		28c. Injury Work			ld. Describe ho			
<u>o</u>	Attending r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		/ 6a/)	Injury	м		Yes 2□N	lo				
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined			ne, farm, str	reet, facto	ry, office		28	If. Location (Sti City or Town	reet and N , State)	umber or Rur	al Route Number,
	he Hospi n 24 hour he Funer pletely fill	ledical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Exa	nysician: To the best of miner: On the basis of and manner sta	examinatio	ledge, deatl on and/or in	h occurre vestigatio	d at the time in, in my op	ne, date and pinion, death	place, an	d due to the ca	use(s) and ite and pla	d manner as a	stated. to the cause(s)
	To t	Σ	29b. Signature and title of certifier				25	oc. License	number		25	d. Date si	gned (Month,	Day, Year)
•	1		to but 31			200		レンら	ا دعی ا		4	45/1	20	
_	4			completed cause of de	ath (Item 2	23a) (Type,	Print)	Press	WAY (	Dire	400	ANNA	folish	10, 2190j
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu معمر	re A	10	ns V	, :					

		1 - State RegistrarAMEND ITEM #10e 1. Decedent's Name (First, Middle, Last)		Z8 '2/	11/04/61	uncate (	л Беа	ш	2. Date of De	Reg. No. ath Day	Year	3. Time of Death
Physic /Medi	cal	WILLIAM AUBREY RO  4a. Facility Name (If not institution, give:	DGERS			4b. City, Tow	m, or Locat	ion of Deal	Febru	ary	9, 200	
Examir	ier	Greater Baltimore		ente	er	Tows				В	altimo	
Funeral Director		5. Social Security Number 6. Sep 219–20–3521 XX	7. Age	(In yrs.	last birthday) Yrs.	If Under 1 Y Months Da	ear If Un lys Hou	der 24 Hrs irs Min		th 10,19	9. Bir Mary	thplece (State or Foreig ountry) / I and
yiand		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. toside City Limits
8a-f sl	Director	Maryland Baltimore		Tows	son							1 □ Yes 2 No
with the	Dire	10e. Street and Number 8 <del>017 Straus Roa</del> d 8	3017 STRAUFF	ROAD	)	10f. Zip Cod 2120					en of What Co ISA	ountry?
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amply injury or other traumatic event, it a Medical Examinar must be notified at since.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 NYes 2 N If Yes, Give Year or Dates:		1	Was Decedent f Yes, specify I □ Yes XX			Specify Yes or No to Rican, etc.)	)- 1	4. Race - Ame Black, Whit	te, etc.
hin 72 hou e. an "natura Medicel E	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	·)	16a. Deced (Give life.	lent's Usual Od kind of work do DO NOT use re	cupation one during i itired)	most of wo	rking	16b. Kir	d of Business	/industry
filed wit Hygien other th		12			Sal	es	10.14	-46 - 4- 81-	- Cina Middle		surance	
should be find Mental H marked off umatic ever	To Be	17. Father's Name (First, Middle, Last) Harry Winfield Rodgers					Co	nstand	me (First, Middle, ce Jones	_,		
id 2 strith and 27 ts m		19a. Informant's Name/Relationship (Ty William A Rodgers Jr	рө, Print) SC	n					ura <i>l Route Numbe</i> Maryland 2:		Town, State, 2	Zip Code)
of Health of Health fitem 27 r other tr		20a. Method of Disposition				sition (Name of natory or other		1	Date		cation - City or	Town, State
ment of ment of lant: if it jury or o		XX Burial 2 □ Cremation 3 □ R  *4 □ Donation 5 □ Other (Specify)	lemoval from State		id Ridge	Cemeter	/	2/12				Maryland
Depertrit. Depertrit Imports any inju		21 A nature of Funeral Service License  Lennus Stephe	in Kena	kes	ر ا	. Name and A	6500 Y	acility Mi York Ro	tchell-Wie ad Baltim	edefel ore, M	d Funera aryland	l Home Inc 21212
nysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line.  Due to (or as a	tati	c M	er the mode of		as cardia	c or respiratory a	rrest,		Approximate Intervat Between Ons. and Jeath
that the death certificate be executed  ed by the attending physicien and detached for use as the burial-fransit	dicai Exaniner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a									
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	Feta	death 3	Ectopic pregna Other (specif)				2	3d. Date of del Month	ivery Day Year
w requires that been signed be should be deta	ed by PI	Part II. Other significant conditions con In vasure Actenacar	-	1 1		nderlying cause	given in P	art I.	23e. Did to		/	o the cause of death? obably 4 □Unknow
sicien: The law re- certificate has bee irector, page 2 sho		Insulus Dezenda	A Diase	ts	melli	Tus			1 Tes	osy rmed? 200 No	prior to death?	utopsy findings available completion of cause of 2 No
this ald	25. Was case referred to medical examiner?  1							26. Place of Death (Check only one)  It 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Special Section of the Sec				cify)
Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At ho (Specify	ome, farm, str	et, factory, off	СӨ		28f. Location (S City or Tox	Street and vn, State)	Number or Ru	ıral Route Number,
affe i Dir din	Medical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sicien: To the best of ner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at the	e time, date ny opinion,	and place death occu	e, and due to the urred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
ne Hospitel or n 24 hours afte ne Funerel Dir sletely filled in	0			10000		29c. Lic	ense numb	er		29d. Date	signed (Menti	h Day Year)
To the Hospitel or Attending Physicien: The within 24 hours alter death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Six ature and title of certifier	erad III	WD		23.	3400			02/	09/20	04

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 0 0 1 03740 State RegistraMEND ITEM #1 PER PHY G828 2/10/04 JCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10054M MARY RIESNER Mary Pcisier Felman 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Center Randalls town Nathwest Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Jan 20, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours Min. 1 □ M 20X F 80 1924 Director 213-20-6982 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exactmer must be notified at 1 ☐ Yes 2 No Directo MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with or Items 23a or 214 Northway Road 21136 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Soecify: Specify: 3₺ Widowed 4 Divorced White "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental t Health and Menta 2 Maurice Sturm Elsie Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jane Mannion Daughter 1304 Ceorgetown Drive Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or ^ 4 □Donation 5 □ Other (Specify) Garrison Forest Vet Cem 2/11/04 Owings Mills, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. ELINE FUNERAL HOME Reisterstown, MD 21136 Immadiate Cause (Final Physician distructive pulmonary chuanic resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. as the guipi IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 XNo P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 🗆 No 3 ☐ Probably 4 ☐Unknown 1X Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : has autopsy performed2 certificate 2 🗆 No 2 No 1 Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Division 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No NIA the Director 6 Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00000567 Felaman 7 2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mejia, MD 5401 Manyjoy Old courtroad Randallstown, Mayland 21133 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

1 0 2004

			For	State of Marylan				and Mental H	lygiene	2001	00711
			1 - State RegistramEND ITEM #19a	PER FH G828 2/10,	/04 <b>S</b> APE	rtificate of	Death	100.4	Reg. No.	2004	
٦	Physicia	an	Decedent's Name (First, Middle, Last)	0 0				2. Date of Month	Day		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s	CODNER		4b. City, Town, o	y Location o	vf Death	05	County of Death	
	Examin	er		Lèsi, lle		Pilesvil	1	MI	0	11 -	
	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	If Under	24 Hrs.   8 Date of I	Rirth	9. Birth	plece (State or Foreign
	Director		213-70-5445 <sup>1□</sup>	M 20% F	5 Yrs.	Months Days	Hours	Min. JUNE	12,19	17 PA	LESTINE
	pu &		Usual Residence of Decedent  10a. State 10b. County	10c Cib	, Town or Lo	ocation					10d. Inside City Limits
	Aaryla I sho	ō	MD BALTI			ESVILLE					1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	THORE	1 11	10f. Zip Code			10g. Citiz	zen of What Cou	
	3 or		3800 OLD COURT RO	AD			212	08			U.S.A.
	death	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	dispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ameri Black, White	can Indian,
9	or its	F	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2 💢 No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:	WHITE
Ö	hours tural',	d by	3 XX Widowed 4 □ Divorced	Year or Dates:	163 Daca	dent's Usual Occup	nation		16h Kir	nd of Business/Ir	
5	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done  DO NOT use retire	during most	t of working	100.10	ing of businessyn	loustry
21215-0036	d with piene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	HOME	MAKER			OW	N HOME	
פ	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or Itams 23e or 28a-f show event, I'ra Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)		14.		18. Mothe	er's Name (First, Midd	dle, Maiden	Sumame)	
<u> </u>	should b ind Ments marked umatice	To	BENJAMIN		LEV			CHEL			NKNOWN)
Maryland	2 sho		19a. Integrants MODINERY SON (TV)	pe, Print)				or or Rural Route Nur			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itams 23e or 28a-1 show eny injury or other traumatic event, the Medical Examinat must be rediffed at 200e.		LES RODNER / SON  20a. Method of Disposition	20b. P		MAKKET 3 sition (Name of	IKEEI	EAST - GA	7	cation - City or T	
altimore,	Pages nent of I int: If it		1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emovaj/rom State	emetery, cre	matory or other play OUNG MEN		2/8/2004		IOODLAWN	
	nit. Parime ortan injur.		21. Signatura of Funeral Service Census	1//		2. Name and Addre			-		
ã	permit. Departr Imports eny inji		MIMOROU 7	Jugar		8900 REIS	TERST	OWN ROAD -			
			23a. Peri 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death							Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition			mEn'S					Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a consequ							
į,	Examine	L	Sequentially list conditions, b	Due to (or as a consequ	10000 of/:					-	
	19d	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	derice or).						
•	icate be executed physician and s the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):						
8760,	ysicia e buri	dlcall		1							
9		Medi	IF FEMALE:								
Вох	death certific e attending p ed for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		☐Ectopic pregnanc	у		2	23d. Date of deliv Month	ery Day Year
0.	0 0 0	/slci	1 Yes 2 Ho	4□Pregnant at time of do 9□Unknown	eath 5	Other (specify) _			-		24,
ď.	The law requires that the de tie has been signed by the page 2 should be detached		Part It. Other significent conditions con	ntributing to death but not resi	ulting in the u	inderlying cause giv	ven in Part I.	. 23e. Di	d tobacco u	se contribute to	the cause of death?
Vital Records,	requires been signe should be	Completed by		•		, ,		1[	]Yes 2√2	No 3 Pro	babiy 4 🗆 Unknown
S	w requ	lete						24a. W	as an	24b. Were aut	opsy findings available
Re	The lav	dwo						pe	topsy formed?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of
a		0	25. Was case referred to medical				26. Place	1 ☐ Yes		1 1 103	ASSISTED
	G 88 7	To B	examiner?	fospital: 1 tnpatient 2	ER/Outpatie	nt 3 DOA Ott	ner: 4 □ Nu	rsing Home 5 🗆 Re	esidence 6	6 XOther (Speci	
n of	ding Pt		27. Manner of Death  1.☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describ	e how injury	y occurred	
Sio	Attending r death.	catl	2 Accident investigation 3 Suicide 6 Could not be	an Bloom Allain Alla			]Yes 2 □ I		- (Ct	al Morahan an Dou	at Davida Aliverbas
Division	or Attendate death	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office		City or	Town, State,	a Number or Hur )	al Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier + Certifying Phys	 sician: To the best of my kno	wledge, dea	th occurred at the ti	me, date an	d place, and due to the	ne cause(s)	and manner as	stated.
	n 24 h	edical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	tion and/or in	nvestigation, in my o	opinion, dea	th occurred at the tim	e, date and	place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled in	M	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
	4		healtents	mus		25	345	0	2	-5-0	4
	10		30. Name and address of person who co	impleted cause of death (Item	23a) (Type	Print)		1 . / /	has.	2110	7
	-0		31. Date filed #Months Daly, Par ANA	PILED MIS	ture 2	os you	NCH	LA M	7000	surs	
	Sta	ne	FEB 7 0-2004	ARGERIAL PS	Contract of the last						

			riease	Type of Fillt in				_	
			1 - For State Registrar Amend Item 21	State of Maryla	nd / Departme	ent of Health and I		/ 111114	03742
					2010 1861 11110	ite of Death	Reg.	No.	3. Time of Death
	Physici /Medic		1. Decedent's Name (First, Middle, Las MARGARE	T SIM	PSON		Feb. (	Day 2004	10:15 PM
1	Examin		4a. Fecility Name (If not institution, give	street and number)	4b. Ci	ty, Town, or Location of Deeth		4c. County of Death	
1			Bon Secour	< HASAI	tal I	Paltimore	,	NIA	
	Funeral		5. Social Security Number 6. S			fer 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birth	plece (State or Foreign intry)
п	Director		120-14-0242 1	OM 200F 27	Yrs. Month	s Days Hours Min.	Cont. Day, Yo	1916 Vir	ainia
			Usuel Residence of Decedent				NATION	11121	Jima
	ahow		10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	Man	ō	Maculand 11	A 7	Rultim	ore_			1)XYes 2□No
	28a 28a	Directo	10e. Street and Number			Zip Code	10a.	. Citizen of What Cou	intry?
	with a or	ā	11020 6	an Day	1 10	21207		110	A
	s 23	a.	7808 GWY1	12. Was Decedent Ever in	Me. 13 Was Da	X   X U	noofy You or No	14. Race - Ameri	icen Indian
	er de	un n	11. Marital Status	Armed Forces?	If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puert	Rican, etc.)	Black, White,	
36	s after	Ϋ́	1 Never Married 2 Married	1 □ Yes 2 X No If Yes, Give	1 ☐ Yes	25 No Specify:		Specify: 7)	ack
8	ural'	d b	3 ⊠Widowed 4 □ Divorced	Year or Dates:				1 51	ack
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or litems 23e or 28e-1 ehow ta Madical Ezammar mual be motified at	Completed by Funeral	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's U (Give kind of	work done during most of work	king 160	b. Kind of Business/Ir	ndustry
2	within lene. than	dr	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	122 - 1		0 110	6/2000
	filed w Hygier Sther ti	် ပ	12		1 HOM	emarer		UWN	TUME
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Mai	den Sumame)	
<u>a</u>	Mental Mental arked c	ို	William SI	nepherd		Carrie	2 Mae	DUKE	25
Maryland	2 should and Men Is marke aumatic	ľ	19a. Informant's Name/Relationship (	Type. 1 1 aaughte	19b. Mailing Addre	ess (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zij	p Code)
Σ	nd 2		Ms. Gretcher	Simpson	3768 1	dumbus	Drivo	Balton	11.21215
ē,	iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Heath and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehover or other traumatic event, the Medical Experiment intellibration or other traumatic event, the Medical Experiment intellibration.	-	20a. Method of Disposition	20b.	Place of Disposition (*	lame of	Date 200	c. Location - City or T	own, State
2	nt of nt of t: If It	1	1 ⊠ Burial 2 □ Cremation 3 □		cemetery, crematory o	1 L 2/14	12004 1	· Inonne	- I being
Ħ	it. Pag riment riant; I njury o	1	'4 □ Donation 5 □ Other (Specify		irview	Cemetery!		aperpe	1 VII giris
Baltimore,	permit. Pag Department Important; eny injury e		21. Signature of Funeral Service Licen  Joseph L, Russ		# Josep	and Address of Facility	uneral	Home -	
_	EU 2 e u		turbes Horse		2222	W. North Av	e. Balti	5. Md. 2	1216
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea one ceuse on each line.	ath. Do not enter the m	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Canapiti	ve Hea	rt Failure			Onset and Death
	/Medical		resulting in death)	Due to (or as a conse					
3	Examiner			PLEUTAL	EFFUS	100)			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		1 "			
	hen	튵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	atrici	Fihr	ilation			
	al-tra	Examiner	resulting in death) Last	Due to (or as a conse	equence of):				
200	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	calE							
687	phys the		_	. d					
×	ding ding	/Me	IF FEMALE:	23c. If yes, outcome of pregi	nancy/				
Вох	ath c ttenk or us	a L	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	tal death 3 Ectopic			23d. Date of deliv Month	ery Day Year
	e de he a he d	20	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5 Other	(specify)			,
P.O.	at the	Physician/Medi							
	as th gned		Part II. Other significent conditions of	ontributing to death but not re	esulting in the underlying	g cause given in Part I.		co use contribute to t	
Ď	quire an si	Completed by					1 ☐ Yes	2 □ No 3 □ Prol	bably 4 Unknown
00	w re	et					24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
Re	he la e ha	Ē					autopsy performed 1 Yes 2	prior to co	1
a	n: T ficat or, pa		25. Was case referred to medical					No 1 □ Yes	2/2Mo
ξ	Physician: this certificatal director, i	Be	examiner?	Hospital:	7	Other	th (Check only one)		
of	Phys this aldi	۲.	1 Yes 2 No 27. Manner of Death	28a ate of Injury	ER/Outpatient 3	4 Indising h	ome 5 ☐ Residence	e 6 Other (Specia	fy)
2	ling After uner	lo u	1 Natural 5 ☐ Pending	28a. ate of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describe now	illiary occurred	
Sic	Attendia death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be		1		006 1		10
Division of Vital Records,	or At fter of jirec n by	ii.	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, rarm, street, ract cify)	ory, office	City or Town, S	t and Number or Run State)	ar Houte Number,
	urs a	ပီ	V	4					
	dosp 4 hor une	ca	(Check only 2 Medical Exan	ysician: To the best of my kr niner: On the basis of examin					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	one)	and manner stated.					
	To To	2	29b. Signature and title of certifier	1		29c. License number	_	Date signed (Month,	Day, Year)
	21		Je sonce	damb m.r.	2	D37203	1	eb. 6.0	Y00 Y
	S		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)	1	0 1		1
			1000Ce Um	19 120N S	ecous.	HOSPUTA,	Baltine	ore Mo	<i>7</i> .
7	Sta	ate	31. Date filed (Noting Pay Year)	32. Registrar's Sign	nature				
**	Regist	rar	1 0 200	14 persons	The Same				

ORIGINAL

			1 - For State Registrar	State of Marylar		artment of H			jiene •g. No. 200   L	03743				
	Dhuaiai		1. Decedent's Name (First, Middle, Las.	0				2. Date of Dear	th Day Year	3. Time of Death				
	Physici: /Medic	al	Charles	W. Sprink	le Sr.			1	4 2004	4:00 pm				
E	Examin	er	4a. Facility Name (If not institution, give				Location of Deat		4c. County of Death					
	Funcial		127 Daycoach ( 5. Social Security Number 6. Se		last birthday)	If Under 1 Year	.e Rivei		Baltimon 9. Birth	CE place (State or Foreign ntry)				
	Funeral Director			XM 2□F 88		Months Days	Hours Min.	8. Date of Birth April	6,1915 Ma	ryland				
	p ,		Usual Residence of Decedent	10-0	T					4				
	anytar show	ž	MD Baltin	1	ty, Town or Lo		River			10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	the M	ecto	10e. Street and Number			10f. Zip Code	RIVOI	1	0g. Citizen of What Cou					
	with Sa or	Funeral Director	127 Daycoach	Circle		21220	)		JSA					
	death rns 2:	era	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decedent of H	ispanic Origin? (S		14. Race - Ameri					
9	be filed within 72 hours after death with the Maryland tat Hygiene. od other then "natural", or ttems 23s or 28s-f show event, the Medical Example must be notified at		1 Never Married 2 Married	Armed Forces? 1 □Yes 2 □ No If Yes, Give		it Yes, speciny Cuba 1 □ Yes 2 ☑ No	sn, mexican, Puen Specify:	o Hican, etc.)	Black, White,					
21215-0036	hours ural',	Completed by	<b>3</b> Widowed 4 □ Divorced	Year or Dates:					Specify:Whi					
15-	n 72 nat	iete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king	16b. Kind of Business/Ir	ndustry				
212	s within liene. r then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		naster			BethStee]	L				
b	at Hygied other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, I	Maiden Sumame)					
ylaı	should be filed and Mental Hygi s marked other umatic event, I	To	Clarence	Sprinkle			Laur	a Tyso	on					
Maryland	2 sho and is mu		19a. Informant's Name/Relationship (7						r, City or Town, State, Zij	o Code)				
	is 1 and 2 should of Health and Meritem 27 is marke other traumatic		Robert Sprink  20a. Method of Disposition	Le /son	127	Daycoa	ch Circ	le Balt	imore MD 20c. Location - City or T	own State				
Baltimore,	0 O		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	natory or other place idgeCem	(8)		Baltimore					
Ħ	고 된 원 중 .		* 4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen.											
Ba	permit. Departm Importa eny inju		P. TENNA	1 (2)	Med	300 M	OD.	nnellyf.	uneralHom	eoiEssex				
·	100 MM		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ications that caused the dea	th. Do not en	er the mode of dyin	g, such as cardiad	or respiratory arm	est,	Approximate Interval Between				
è	Physician		Immediate Cause (Final disease or condition							Onset and Death				
ec pf	/Medical		resulting in death)  Due to (or as a consequence of):											
I	Examiner		Succeptibility list conditions	b. HYPER:		SIUN								
1	nsit	Examiner	Securities is transitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	92.5E 15.3	21 TE	1								
	e be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	2057A	16							
8760	ate be o	cal		HYPEL	240	IDIMA	-		1					
9	tificate ng phys as the	ledi							54.01	-				
Вох	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of deliv	,				
	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	4 Pregnant at time of o	death 5	Other (specify)			Month	Day Year				
P.0	that the deed by the detached	Phy	Part II. Other significant conditions or	ontributing to death but not res	sulting in the u	nderbing cause giv	en in Part I	23a Did tol	bacco use contribute to t	he cause of death?				
Records,	uires tha signed d be de	d by	OSTEDAN	4	Jennig III (110 u	ricerrying occuse giv	on an anti-	11	es 2□No 3□Pro					
Sor	w requir been si should	lete	PEURIC	W-101-12				24a. Was a	24h Wara aut	opsy findings available				
Re	2 8 8	Completed						autops perfore	med? prior to co	empletion of cause of				
Vital	ysician: The lis certificate hadrector, page	Be Co	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes	2 No 1 ☐ Yes	2 No				
Ž	Physician: this certifican ral director, I	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	] ER/Outpatie	nt 3 DOA Oth	00	Control in	ence 6 ☐Other (Speci	fy)				
n of	ding Phi h. After thi funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe ho	ow injury occurred					
Siol	Attending r death.	atic	2 Accident investigation				Yes 2□No							
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	reet, factory, office		28f. Location (St City or Town	treet and Number or Run n, State)	al Route Number,				
	Hospital		29a. Certifier 18 Certifying Ph	ysician: To the best of my kn	owlodge deal	h	and alass	and due to the e						
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	irred at the time, d	ause(s) and manner as s late and place, and due t	o the cause(s)				
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Month,	Day, Year)				
			Saba Side	digi MD		D	41496		2/5/200	04				
	(0		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)			1-1-5					
	- Y			5/0/				ROA	O BALTO	MO 21237				
di	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Store	ture	11 Soul	0.			·				
DF	HMH 17 Rev 1/2		FEB	1 0 2004	19. 18. 18 July 3	T. ASSESSED	Kar							
				-		-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ 03744 Certificate of Death. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6,2004 **Physician** 12:05 M **JAMES** ANDREW SMITH, SR. MADILLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST. AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Days Hours Year) 05/09/1914 **Director** 218-10-9196 Virginia 89 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No by Funeral Director MD Baltimore Randallstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21133 4328 Maryridge Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exertina 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supermarket Porter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna Smith Thomas A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2379 Flax Terrace, Balto., MD Maurice P. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Woodlawn Cemetery 2/14/04 Baltimore, MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Ave, Balto., MD21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse, and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to ( x as a consequence of): **Examiner** Olitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner MYV Du to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 1 No or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Aatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide the Hospital within 24 hours a To the Funeral 6 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner state 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 200605 ause of death (Item 23a) (Type, Print) MD St Aques 00514

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

0 2004

ORIGINAL

32. Registrar's Signature

			1 - For State	State o		•		t of H	ealth a		ental Hyg		001	L 0371
			Registrar  1. Decedent's Name (First, Middle	a. Last)			imout	0 01 2	- Cuin		2. Date of Dea	3	00.	3. Time of Death
П	Physici	an	Carmen Q		0						Month Februar	Day 7 2	Year 004	12:30 A M
,	/Medic		4a. Fecility Name (If not institution				4b. City.	Town, or	Location o		rebruar	4c. Count		
Ş.	Examin	er	Continuum Care	-			l .	kesv					Carro	
			5. Sociel Security Number			last birthday)		r 1 Year	If Under:	24 Hrs.	8. Date of Birth (Month, Dey			hplece (State or Foreign untry)
	Funeral Director		212-12-2801	1□M 2X0F	7. Age (In yrs. 84	Yrs.	Months	Days	Hours	Min.	(Month, Dey FEB. 21	, Year) 1010		untry) ryland
			Usual Residence of Decedent				l				<u> </u>	<u>, 1919</u>	I IIC	rryrand
	ylanc # ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mar Har	tor	Maryland Carr	co11		Wes	stmin	ster						1 ☐ Yes Ž☐ No
	r 28.	irec	10e. Street and Number				10f. Zip					l 0g. Citizen of	What Co	untry?
	h wit	Funeral Director	102 Timber Ridg	ge Drive A	Apt. 10	6		2115	57				USA	
	deat	ner	11. Marital Status		edent Ever in U		Was Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or No- lican, etc.)	14. Ra		ncan Indian,
9	after or Ite		1 Never Married 2 Marri		2 XNo		1 ☐ Yes		Specify:	i, rueito i	noan, etc.)		ick, White	
8	ral', c	þ	3 XWidowed 4 ☐ Divorced	Year or D	ates:		1 🗆 162	ZIMINO	эрвигу.			Speci	ry: W	Mhite
21215-0036	filed within 72 hours after death with the Maryland Hygione. Hysione. International control that the than 'natural', or Items 23s or 28s-f show ent, the Medical Examere must be notified at	Completed	15. Decedent (Specify only highes			16a. Dece	dent's Usu	al Occupa	tion urina most	t of workin	na l	16b. Kind of E	Business/l	industry
7	thin	npie	Elementary/Secondary (0-12)	College (1	1-4or 5+)		kind of wo DO NOT u				,			
7	ygien yer th	Cor		2		Pers	sonne	1 Mar				Elect		.cs
<u> </u>	tal Hy od oth	Be	17. Father's Name (First, Middle,	-							(First, Middle,		me)	
<u>8</u>	should be filed within 72 hours after death with the Marylan rid Mental Hygione. Indexed other than "natural," or Items 23a or 28a-f show marked other than "natural," or Items 23a or 28a-f show unatic event, the Medical Examenations.	To	John G. Winds	30r					Mar	1е к	. Goodm	an		
	2 40 50 50		19a. Informant's Name/Relations								Route Numbe			
	of Health		Anne Quarles/da	iugiitei					EL RO		8 Sayv			
or G	of H of H of H of H of H		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from	State	Place of Dispo cemetery, crer	natory or o	other place				20c. Location	- City or	Town, State
Ē	Pages nent of ant; if it ury or o		`4 □Donation 5 □Other (S)		Me	tro Cre	emato	ry, ]	inc.	2/8/0	04	Balt	imor	e, MD
Baltimore,	permit. Pages Department of Important; If It any injury or of once.		21. Signature of Funeral Service	Lice <b>9</b> see		Ĉi	. Name ar Cema t	nd Addres	of Facilit	tv o	f Maryla	and. In	ıc.	
m	89 5 8 9		Thomas Gre	agor 0		20	99 Fr	ederi	ck R	oad	Baltime	ore. MT	212	.28
ê			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that controls one cause on e	caused the dea	th. Do not ent	er the mod	de of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
5 ~ I	Physician		Immediate Cause (Final disease or condition	,		ner								Onset and Death
	/Medical		esulting in death)  Due to (or as a consequence of):										9200	
п	Examiner													
	0	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to	(or as a consec	quence of):								
	uted d ansit	Examiner	Cause (Diseese or injury that initiated events											
o	exec an ar rial-ti		resulting in death) Last	Due to	(or as a consec	quence of):								
760,	icate be executed physician and s the burial-transit	cai		d										
89	The law requires that the death certificat, sie has been signed by the attending phy page 2 should be detached for use as the	led												
ŏ	n cer andin use	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregn		Ectopic p					23d. Da	ate of deli	
Ω.	deat e atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregr	nant at time of		Other (sp					M	onth	Day Year
P.O. Box	that the de led by the a detached f	Physician/Med	9 Unknown	9□ Unkn	own									
ď.	w requires that been signed be should be det	by P	Part II. Other significant condition	ms contributing to de	eath but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	bacco use con	tribute to	the cause of death?
ğ	quire an sig uld b										1 □ Y	es 2 🗆 No	3 ☐ Pro	obably 4 Unknown
Records,	s bee	olet									24a. Was a		Were au	topsy findings available
æ	The law te has age 2 s	Completed									autops	med?	death?	completion of cause of 2 No
a	iclan: Th certificate rector, pag	C	25. Was case referred to medical						26 Place	of Death	(Check only or	2 No	T Tes	2 NO
>	Physiclan: r this certifica ral director, p	o Be	examiner? 1 □ Yes 2 <b>X</b> No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 DC	Othe			ne 5 Reside		nor (Snac	nific)
Division of Vital	tending Physician: The leath.  tor: After this certificate hithe funeral director, page	Τ:	27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injury Work			8d. Describe he			,
0	ding th. : After s funer	tio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Year)	Injury	м		? ′es 2 ∐ l'	No				
18	= 00 >	Certification:	3 ☐ Suicide 6 ☐ Could r	ined 286. Place	of Injury - At h		eet, lactor	y, office		2			ber or Ru	ral Route Number,
á	al or	ert	4 Homicide determ	buildi	ing, etc. (Speci	fy)					City or Tow	n, State)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by			g Physician: To the										
	e Hc 124 t e Fu fetely	edicai	(Check only 2 Medical	Exeminer: On the b	asis of examina	ation and/or in	vestigation	, in my op	inion, deat	th occurre	ed at the time, d	ate and place,	and due	to the cause(s)
	Fo th withir Fo th xomp	Me	29b. Signature and title of certifier	r			29	c. License	number		2	9d. Date signe	ed (Month	, Day, Year)
)	,.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Mun	ND				04	770	24		2/	8/4	24
	9		30. Name and address of person	who completed cau:	se of death (Ite	m 23a) (Type_	Print)	_ /	, ,	,		2	- 1	, <u>&gt; :                                  </u>
			29b. Signature and title of certifier  30. Name and address of person  The Victorian (Month, Day, Year)  FEB 0	PHAN	120	> 4	000	01	16	UNU	TRO	TAIRE	-) 4	CC-ND
	Sta	ate	31. Date filed (Month, Day, Year)	2004 32/F	Registrar's Sign	ature							•	
	Registi		FFB T 0	2004	EUR A	The Agent	and I							

	4-00975	OII	Please	Type or Pr							gible.			
R			For State : Libraria Thomas		-	•		lealth and N		7)	006	0371.6		
			1 - State Unpend Item#2  1. Decedent's Name (First, Middle, La		, PEL ME	5,G020 F2	KIN BY BUBYOLI	Dealii	2. Date of De	Reg. No	004	3. Time of Death		
	Physicia	_	Timothy	Just	in		She1	ton	Februa	ry 3,	2004	0420 PM M		
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and numbe				r Location of Death			nty of Death	_		
			North Arundel Ho				Glen Bu		9 Date of Bir		e Arur			
-	Funeral Director		5. Social Security Number 213-15-9543	Sex 7.4	21	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Oct 9	y, Year) 1982	MD	place (State or Foreign htry)		
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	v. Town or Lo	cation				1	10d. Inside City Limits		
	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Iteme 23e or 28e-f show or other traumatic event, I'm Medical Examinan must be multified at	tor	MD Anne Ar	undel	Se	everna	Park					1 ☐ Yes 2 No		
	or 28s	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?		
	23a c	alD	167 Barbara Roa				21146			USA				
	teme	nue	11. Marital Status	12. Was Deceder	s?	.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. F	Race - Americ Black, White,			
21215-0036	urs aft	by F	M Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates	Λ.		1 □ Yes X □ No	Specify:		Spe	ecify: Whi	te		
5-0	72 ho	Completed by	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Deced (Give	dent's Usual Occup kind of work done	nation during most of world)	king	16b. Kind o	f Business/In	dustry		
121	within ene. then	Juno	Elementary/Secondary (0-12)	College (1-4c	or 5+)		Apprentic			Cans	struct	ion		
<b>d</b> 2	Hygid Other	Be Co	17. Father's Name (First, Middle, Last			1	vppi ent ic	18. Mother's Nam	e (First, Middle			1011		
ılan	dental Mental rkad ric ev	To B	Kenneth George	Shelton				Linda	a Lee H	aycock				
Maryland	and hais ma		19a. Informant's Name/Relationship					a <i>nd Number or Ru</i>						
	fealth fealth orn 27 ther tr		Mr. Kenneth She	lton / Fa			Barbara R	load Sevi	Date	20c. Locatio	2114 on - City or To	5 own, State		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ange.		1 ☐ Burial 2 ☑ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci	☐Removal from Sta	.   0	emetery, crer	natory or other plac ke Cremat	Febru Fion 7000	uary 8		nsvill			
3alti	permit. Page Department of Important: If any injury of ange.		21. Signature of Funeral Service Lice	nsee				ss of Facility Si				art control and the		
	705 a		233 American disease of con		2 20			venue SW			MD Z	1061 Approximate		
	6. 20.		nock, or heart failur. List only one cause on each line.  Interval Betwoonset and Discourse (Final Nagroctic Throwing Th											
	Physician /Medical		disease or condition resulting in death)  NATICULTS ITHOURISEASTORY  Due to (or as a consequence of):											
	Examiner		Sequentially list conditions,	b			<del></del>							
	nsit	Examiner	Sequentially list conditions, if any, bacing to immediate cause. Enter Underlying Cause (Disease or injury	Due to Lor	as a cons⊯3	neuce of:								
	be executed icien and burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or	as a conseq	juence of):								
1760,	certificate be execut oding physicien and ise as the burial-trar			_ d										
(687	ing ph	Med	IF FEMALE:											
O. Box	ne death the atter	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1□Live birth 4□Pregnant 9□Unknowr	2 ☐ Feta tat time of d	Il death 3	Ectopic pregnanc Other (specify)	у		23d.	Date of delive Month	ery Day Year		
۵.	s that the	y Ph	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?		
rds	equires en sign								10	Yes 2□N	o 3 Prot	bably 4 QUnknown		
Vital Records,	0 5 0	Completed									b. Were auto prior to co death? 1 🖾 Yes	opsy findings available ompletion of cause of		
ita	icion: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Dea						
of V	Physicien: rthis certific ral director,	၉	1½ Yes 2 No	Hospital: 1 Inpe		ER/Outpatier	" 3 DOA		ome 5 Res			fy)		
ou o	ng Inel	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigate		did ear)	28b. Time o Injury <b>£</b> 11:05	ound Wo	rk? ]Yes ŽV⊠No	28d. Describe		cuirea			
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigate 3 Suicide 5 Could not determined	be 28e. Place of		ome, farm, st	reet, factory, office		28f. Location		umber or Rur	al Route Number,		
Ö	urs afte			resid	ence				467 Barba	ara Rd.,		Park, MD		
	To the Hospitel or within 24 hours after To the Funerel Diccompletely (Illed in	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the be miner: On the basi and manner	s of examina	owledge, deat ation and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) and date and pla	manner as s ce, and due t	o the cause(s)		
	To the Within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens				gned (Month,			
			> ariest				0.C.				ary 4,			
			30. Name and address of person who	completed cause	of death (Iter	т 23а) (Туре,	Print 111 Pe	nn Street	, Balti	more,	Maryla	and 21201		

State Registrar

31. Date filed (Month, Day, Year)
FEB 1 0 2004 32. Registrar's Signature

pouls

		1 - For State Registrar	State	of Maryland		artment of H tificate of I			jiene 2001	+ 03747
Physici /Medi		1. Decedent's Name (First, Middle		ulliva	-N			2. Date of Dea Month	Day Year	3. Time of Death 11:50 Aм
Examir		4a. Fecility Name (If not institution, 2021 Bay Driv	give street and n			4b. City, Town, or Pasad	Location of Death		4c. County of Dea Anne Aru	
Funeral Director			6. Sex 1  M 2  F	7. Age (In yrs. la 76	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 2		thplace (State or Foreign ountry) WYLAND
pu *		Usual Residence of Decedent  10a. State 10b. County			Town or Lo	cation				10d. Inside City Limits
the Mar 28e-f at nutitied	rector	Maryland Anne A	rundel			Pasadena 101. Zip Code		1	0g. Citizen of What C	1 ☐ Yes 2 No
eth with s 23a of	Funeral Directo	2021 Bay Drive	1.0 1/1		140 (		21122		u.s.A.	
ite, INICAL YICATION CINES TO SOLVE STEED With the Maryland of and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural, or items 23e or 28e-f ahow other treumatic event, the Maxified Example or unit be notified at	by Fune	11. Marital Status  1 □ Never Married 2 1 Marrie  3 □ Widowed 4 □ Divorced	Armed F	2 No	_   "	vas Decedent of H Yes, specify Cuba □ Yes 2ሺ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, Whi Specify:	
nin 72 hou n "natura Madical E	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education grade completed	)	16a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work l)	king	16b. Kind of Business	Andustry
yiding Z 12 buld be filed with Mental Hygiene arkad other tha atic event, the		12th Grade  17. Father's Name (First, Middle, L		(1-4or 5+)	Lith	ographer	18. Mother's Nam	e (First, Middle )	Printing Maiden Sumame)	
yidili louid be i Mental parkad o natic eve	To Be	Frank R. Sulli	van, Sr.				Anna	C. Lo	rch	<u></u>
y, Mid.		19a. Informant's Name/Relationsh Mrs. Assunta Su		(wife)			end Number or Rui 1e, Pasad		; City or Town, State, . 21122	Zip Code)
ages 1 and nt of Health r: If Item 27		20a. Method of Disposition 1   XBurial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		State Cer	netery, crem	sition (Name of natory or other place	θ)		20c. Location - City or Baltimore,	
parmit. Pages of permit. Pages of permit. Pages of permit of the important: If its any injury or of once.		31 Signature of Funeral Service	-	buca	22	Name and Address	s of Facility Sc	himunek	Funeral Ho , MD 21236	mes
· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the death.						Approximate Interval Between
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	Or as a seque	-	3 6	ranulo	matc	2120	Onset and Death
Examiner	Jer	Eequentially list conditions, if any, leading to immediate	b Due to	(or as a conseque	ence of):					
cate be executed cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseque	ence of):					
ificate be ex g physician as the buria	edicai		d							
Physician: The law requires that the death certificate has been signed by the attending ribit certificate has been signed by the attending rail director, page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnant birth 2 Fetal d mant at time of dea nown	leath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
w requires that the been signed by should be detack	by	Part II. Other significant condition	ns contributing to	death but not result	ing in the un	derlying cause give	an in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
To the Hospitel or Attending Physicien: The law requivilin 24 hours after death.  To the Funerel Director: After this certificate has been scompletely filled in by the funeral director, page 2 should	Completed							24a. Was an autops perform	v prior to	utopsy findings available completion of cause of
ysician: Thysicians certificate	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2 E	- R/Outpatient	3□ DOA Othe	26. Place of Deat	h (Check only on		cifv)
SICH CI tending Phys leath. tor: After this the funeral dir	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date (Mo		8b. Time of Injury	28c. Injury Work			w injury occurred	3.177
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	200. Flat	e of Injury - At hom ling, etc. <i>(Specity)</i>	ne, farm, stre	et, factory, office		28f. Location (Sti City or Town	reet and Number or Ri i, State)	ural Route Number,
ne Hospi 24 hou ne Funer pletely fill	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	e best of my knowl basis of examination oner stated.	ledge, death on and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To th To th	Ň	29b. Signature and title of certifier	11/1	0	Z	29c. Licence	number 3	25	9d. Date signed (Mont	h, Day, Year)
H1		30 Name and address of person v	no completed cau	ise of death (Item	23a) (Type, F	Print)	79. B	1. BI	102 Md	2061
Sta Registi		31. Date filed (Month, Day, Year) FEB 1 0 20		Registrar's Signatu	re G	1	7	(1)00	1) 11 1	

DHMH 17 Rev 1/2001

ORIGINAL

nysicia Medic		<ol> <li>Decedent's Name (First, Middle, Last,</li> </ol>	Pa PER FH G828 2/10/05		2. Date of Dea Month	Day Year
Physicia /Medica Examine		DENN	SOBER	02	05 2004 0830AM	
		4a. Facility Name (If not institution, give		4b. City, Town, or Location of BALTIMORE	CITY	4c. County of Death
neral ector		5 Social Security Number 6 Se	x 7. Age (In yrs. last birth	day) If Under 1 Year   If Under 24		9. Birthplace (State or Foreign Country)
s or 28a-f show be notified at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	rai Director	MD BALTIM	ORE	OWINGS	MILLS	1 √Yes 2 No
		10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
		28 WIMBLEDON LAN	12. Was Decedent Ever in U.S.	211		U.S.A.
	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes, Give Year or Dates:	<ul><li>13. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican, I</li><li>1 ☐ Yes 2 ☑ No Specify:</li></ul>	Puerto Rican, etc.)	Black, White, etc.  Specify: WHITE
lical E	eted	15. Decedent's Edu (Specify only highest grad	ie completed)	Decedent's Usual Occupation Give kind of work done during most of	of working	16b. Kind of Business/Industry
분	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) NANAGER		PHARMACY
event.		17. Father's Name (First, Middle, Last)	<u>-</u>		s Name (First, Middle,	Maiden Sumame)
9 9	To Be	HAROLD		SOBER BE	VERLY	BANKS
other treumatic	1	19a. Informant's Name/Belationship (7		Mailing Address (Street and Number 28 WIMBLEDON LANE		
other t		SUSAN SUBLITY SUBER/ WIT 20a. Method of Disposition	20b. Place of	Disposition (Name of	Date	20c. Location · City or Town, State
= 5		1 Donation 5 Other (Specify	Hemoval from State	crematory or other place) ORE HEBREW CEM. 2	/8/2004	REISTERSTOWN, MD
sny injury once.		21. Signal Molymeral Service of ne	TMM ON-	22. Name and Address of Facility 8900 REISTERST	SOL LEVI OWN ROAD -	NSON & BROS., INC. PIKESVILLE, MD 21208
		23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death. Do no	ot enter the mode of dying, such as co	ardiac or respiratory ar	rest, Approximate Interval Between Onset and Death
ledical aminer nrial-transit						
siciari and buriat-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence of			
or use as	edical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			23d. Date of delivery Month Day Year
be detached for use as	by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	C	f):  3 □Ectopic pregnancy 5 □ Other (specify)	23e. Did to	Month Day Year obacco use contribute to the cause of death?
ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	C	f):  3 □Ectopic pregnancy 5 □ Other (specify)	1 🗋 24a. Was autor	Month Day Year  obacco use contribute to the cause of death?  Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown  an 24b. Were autopsy findings available prior to completion of cause of death?
been signed by the attending should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown  Part II. Other significant conditions of examiner?	C. Due to (or as a consequence of d	f):  3 □Ectopic pregnancy 5 □ Other (specify)  the underlying cause given in Part I.	24a. Was autor	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 □ Probably 4 □ Unknown  an 24b. Were autopsy findings available prior to completion of cause of death?  2 No 1 □ Yes 2 □ No
been signed by the attending should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of patient 3 DOA	24a. Was autor perfo	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  an 24b. Were autopsy findings available prior to completion of cause of death?  2 No 1 Yes 2 No none)  dence 6 Other (Specify)
fler this certificate has been signed by the attending ineral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions of examiner? 1   Yes   2   No   2   Yes   2   No   2   Yes   2	Due to (or as a consequence of d	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of patient 3 DOA	24a. Was autor performed to the control of Death (Check only of Sing Home 5   Residue 28d. Describe	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 □ Probably 4 □ Unknown  an 24b. Were autopsy findings available prior to completion of cause of death?  2 No 1 □ Yes 2 □ No
fler this certificate has been signed by the attending ineral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 9 Unknown  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Watural 5 Pending	Due to (or as a consequence of d	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nursime of 28c. Injury at Work?  M 1 Yes 2 N	24a. Was autor performed to the performance of Death (Check only of Sing Home 5 - Residual Re	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No  one)  dence 6 Other (Specify)  how injury occurred
fler this certificate has been signed by the attending ineral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of examiner? 1   Yes 2   No 27. Manner of Death 1   Natural 2   Accident 3   Suicide 4   Homicide   Homicide   Homicide   Homicide   Homicide   Homicide   Locativing Ph.	Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nursime of 28c. Injury at Work?  M 1 Yes 2 N  m, street, factory, office	24a. Was autor performed to the control of the cont	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No one)  dence 6 Other (Specify)  how injury occurred  Street and Number or Rural Route Number, wn, State)
fler this certificate has been signed by the attending ineral director, page 2 should be detached for use a	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nursime of 28c. Injury at Work?  M 1 Yes 2 N  m, street, factory, office  death occurred at the time, date and for investigation, in my opinion, death	24a. Was autor performed to the cocurred at the time,	Month Day Year  obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown  an say prior to completion of cause of death? 2 No 1 Yes 2 No  one)  dence 6 Other (Specify) how injury occurred  Street and Number or Rural Route Number, wn, State)  cause(s) and manner as stated.
To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions of examiner? 1   Yes   2   No   27   No   27   No   27   No   27   No   27   No   27   No   28   No   29   No   27   No   27   No   27   No   28   No   29   No   29   No   29   No   29   No   20   No   20	Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nursime of light Work?  M 1 Yes 2 Num, street, factory, office  death occurred at the time, date and for investigation, in my opinion, death	24a. Was autor performed to the hoccurred at the time,	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  an 24b. Were autopsy findings available prior to completion of cause of death? 22 No 1 Yes 2 No  one)  dence 6 Other (Specify)  how injury occurred  Street and Number or Rural Route Number, wn, State)  cause(s) and manner as stated.  date and place, and due to the cause(s)
fler this certificate has been signed by the attending ineral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions of examiner? 1   Yes   2   No   27   No   27   No   27   No   27   No   27   No   27   No   28   No   29   No   27   No   27   No   27   No   28   No   29   No   29   No   29   No   29   No   20   No   20	Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  ontributing to death but not resulting in  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home, far building, etc. (Specify)  yesician: To the best of my knowledge niner: On the basis of examination and and manner stated.	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place patient 3 DOA Other: 4 Nursime of 28c. Injury at Work? 1 Yes 2 N  m, street, factory, office  death occurred at the time, date and for investigation, in my opinion, death  29c. License number	24a. Was autor performed at the time,	Month Day Year  obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No  obense 6 Other (Specify)  how injury occurred  Street and Number or Rural Route Number, wn, State)  cause(s) and manner as stated. date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vaar SILKWORTH FEBRUARY 3.00 **Physician** JOSEP 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE AVENVE YA LE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 16, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours **Funeral** 1 X M 2 □ F Ĩ**9**28 217 20 5629 75 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State Show ir than "natural", or items 23a or 28a-f show tre Medical Examinat must be notified at 1X Yes 2 No N/A Baltimore Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 451 Yale Avenue 21229 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No 1 □ Never Married 2 □ Married 1 ☐ Yes 2√2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Inspector permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient importent: if item 27 is marked other than any injury or other traumatic event, Italy 00028. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (not available) (not available) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Stinebaugh Sr. 4306 Belle Grove Road Baltimore, Maryland 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 2/9/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signal of Fureral Service Ligen 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COPP Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) YEARS ADDICTION Examiner Sequentially list conditions, Due to (ur as a consequence of) ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of completely filled in by the funeral 27. Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 4 - Homicide To the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier MD onan, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE 900 ANNA 2AN 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 0 2004 Registrar

in al	For State	-	Department of Health and Certificate of Death	Mental Hygier	2001.	03750		
	Registrar  1. Decedent's Name (First, Middle, Las		Commodito or Dodgi.	2. Date of Death		3. Time of Death		
di a	E11a B.	Swinton		Februar	3,2004	1154D M		
er	4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death			
	5. Social Sadurity Number 6. Se	ral Hospital	Baltimure	s. 8. Date of Birth	N/A	place (State or Fernian		
		7.4.087.5	Yrs. Months Days Hours Min	(Month, Dey, Ye	947	plece (Stete or Foreign intry) SC		
1	Usual Residence of Decedent	I 100 City Tarre				10d. Inside City Limits		
ក	10a. State 10b. County N/A	10c. City, Tow	Baltimo	re		1⊠Yes 2 □ No		
Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?		
<u></u>	501 West Frankli	in Street	21201		USA			
Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rece - Ameri Black, White			
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	Black		
edit	15. Decedent's Ed	ucation 16a.	Decedent's Usual Occupetion	16b	. Kind of Business/Ir	ndustry		
plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	orking				
Completed	Unknown		Homemaker	ame (First, Middle, Maid	Househ	old		
o Be	17. Father's Name (First, Middle, Last)  James Manr	n Swinton	Elzi	211.	binson			
္	19a. Informant's Name/Relationship (7		. Mailing Address (Street and Number or F			p Code)		
	Geralena Swintor		365 Union ST., Apt					
	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State cemeter	Disposition (Name of ry, crematory or other place)	h. 08	Location - City or T	22.74.20		
	* 4 ☐ Donation 5 ☐ Other (Specify  21. Signeture of Fureral Services Lices		Haven Cemetery   22. Name and Address of Facility		ullins, S			
	21. Signeture of Futeral Survice Cice.	Zz /.		Stallings				
	23a. Part1. Enter the disease, or comp	plications that caused the deeth. Do	3111 Mountain Ro not enter the mode of dying, such as cardio	ec or respiratory arrest,	a, MD 211	Approximate Interval Between		
	Immediate Cause (Final <sup>∜</sup>	/10 /	cular Auria	'ent		Onset and Death		
	resulting in death)	a						
0	Sequentially list conditions,	b. Sepsis  Due to (or as a consequence	of):					
min	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury the United States when the Cause (Disease or injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when the Cause (Disease or Injury the United States when t							
Exa	resulting in death) Last	Due to (or as a consequence	of):					
ilcai		d						
/Mec	IF FEMALE:	23c. If yes, outcome of pregnancy			23d Date of dollar	(en/		
cian	in the past 12 months?	1 Live birth 2 ☐ Fetel death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Month	Day Year		
hysi	9 Unknown	9□ Unknown		<u> </u>				
by P	Part II. Other significant conditions of	ontributing to death but not resulting i	n the underlying cause given in Part I.			./		
ted								
pid				autopsy	24b. Were autoprior to co	opsy findings available ompletion of cause of		
E	25 Was referred to medical		OS Place of D		No 1 ☐ Yes	2 No		
	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Othor		6 ⊡Other (Speci	(fv)		
Be	27. Mann of Death					,		
To Be			M 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No				
To Be	Z L Addidont		28f. Location (Street end Number or Rural Route Number, City or Town, State)					
To Be	E LI Modidont	28e. Place of Injury - At home, fa building, etc. (Specify)	, stroot, ractory, arrivo	City or rown, Si	(are)			
Certification; To Be	3 Suicide 6 Could not be determined	building, etc. (Specify)				stated.		
Certification; To Be	3 Suicide 4 Homicide  6 Could not be determined	building, etc. (Specify)  ysician: To the best of my knowledge	e, death occurred at the time, date and placed or investigation, in my opinion, deeth occ	ce, and due to the cause	e(s) end manner as	stated. to the cause(s)		
To Be	3 Suicide 6 Could not be determined	building, etc. (Specify)  ysician: To the best of my knowledge niner: On the basis of examination ar	e, death occurred at the time, date and pla	ce, and due to the cause curred at the time, date	e(s) end manner as	to the cause(s)		
edical Certification; To Be	3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	ysician: To the best of my knowledgeniner: On the basis of examination are and manner stated.	e, death occurred at the time, date and pland/or investigation, in my opinion, deeth occurred at the time, date and pland/or investigation, in my opinion, deeth occurred at the time, date and pland/or investigation.	ce, and due to the cause curred at the time, date	e(s) end manner as and place, end due	to the cause(s)		
edical Certification; To Be	3 Suicide 4 Homicide  Could not be determined  29a. Certifier (Check only one)  Could not be determined	ysician: To the best of my knowledgeniner: On the basis of examination are and manner stated.	e, death occurred at the time, date and pland/or investigation, in my opinion, deeth occurred at the time, date and pland/or investigation, in my opinion, deeth occurred at the time, date and pland/or investigation.	ce, and due to the cause curred at the time, date	e(s) end manner as and place, end due	to the cause(s)		
Completed by Physician/Medical Examiner	o pe completed by injoining medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in death)  25. Was case referred to medical examinar? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outer (Disease)   Inpatient 2   Inpat	23a. Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardic shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or	23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failbre. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Lee boo vas cullar Audient  Due to (or as e consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a conse	23a. Part I. Enter the dihease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock or heart failure. List only one cause of each line.  Immediate Cause (Final disease) or complications of the control of the cause		

	1	For State Registrar	State of Maryland		artment of Health and rtificate of Death		giene 20	04 0375	
ysicia: Aedica	n	1. Decedent's Name (First, Middle, Last)  Margaret Ar	nna Shifl	ett		2. Date of De. Month Febryar	Day	3. Time of Death 904 4:05 A	
amine	_	4a. Fecility Name (If not institution, give			4b. City, Town, or Location of Dea	ith	4c. County of	of Death	
		8388 Oakwood Road  5. Social Security Number 6. Sec		ast hirthday)	Millersville		Anne	Arundel  9 Birtholaca (State or Forei	
eral ctor			M 2⊠F 7		Months Days Hours Min		1932	9. Birthplace (State or Forei Country) MD	
the Nedical Executor must be notified at	tor	10a. State 10b. County  Maryland Anne Art		, Town or Lo	Millersville	9		10d. Inside City Limit	
90	Directo	10e. Street and Number			10f. Zip Code		10g. Citizen of W		
Tarast .	era	8388 Oakwood Road	] 12. Was Decedent Ever in U.	S 13	21108 Was Decedent of Hispanic Origin?	Specify Yes or No		USA - American Indian,	
EXECUTAL	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1  ☐ Yes 2  ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	nto Rican, etc.)	Black Specify:	White, etc. White	
	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)	(Give	dent's Usual Occupation kind of work done during most of w	orking	16b. Kind of Bus	siness/Industry	
	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	ше.	Homemaker		Нои	sehold	
	BeC	17. Father's Name (First, Middle, Last)			· · · · · · · · · · · · · · · · · · ·	ame (First, Middle,			
	E OL	Albert Wa	lter Dehr		Lill	ian	Unkno	wn	
		19a. Informant's Name/Relationship (T) Linda L. Shiflett	oe, Print) (daughter)		ng Address <i>(Street and Number or I</i> 8 Oakwood Road, N				
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		lace of Dispo emetery, crea	osition (Name of matory or other place)	Date 10		City or Town, State	
		* 4 □ Donation 5 □ Other (Specify)	Cec					e, Maryland	
ence.		21. Signature of Funeral Service Picens			2. Name and Address of Facility 3111 Mountain Roa			ral Home, P.	
an cal ner		23a. Part1. Enter the visease, or compi shock, or heart if ture. List only of immediate Cause (Final disease or condition resulting in death)		10 (G)	ter the mode of dying, such as cardi		rrest,	Approximate Interval Between Onset and Death	
	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Each in any in Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
	Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1	death 3	□Ectopic pregnancy □ Other (specify)		23d. Date Mon	o of delivery th Day Year	
	y Pr	Part II. Other significant conditions co		ulting in the u	underlying cause given in Part I.	23e. Did t	obacco use contri	bute to the cause of death?	
	ted t	Congestive 1	ear to	un	1 🗆 Ye		Yes 2₽No	es 2 No 3 Probably 4 Unknow	
	Comple	<u> </u>				24a. Was autor perfo 1 🗆 Yes	osy participation produced?	/ere autopsy findings availa rior to completion of cause o eath? □ Yes 2 □ No	
1	Be (	25. Was case referred to medical examiner?				eath (Check only o	one)		
	P.	1 ☐ Yes 2 ☐ No 27. Manner of Death		ER/Outpatie		Home 5 Reside		* * * * * * * * * * * * * * * * * * * *	
	Certification:	1	Matural 5 ☐ Pending (Month, Day Year) Injury Accident Investigation			28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number.			
								or Hurar House Number,	
completely tilled in by the funeral director,	Medical				th occurred at the time, date and pla rvestigation, in my opinion, death oc				
	M	29b. Signature and title of certifier	121		29c. License number		_	(Month, Day, Year)	
		12	000		1) 23624		02/05	12004	
カー		30. Name and address of person who c Basant Khandelwal							
1							MD 21	061	

DHMH 17 Rev 1/2001

ORIGINAL.

		4	_ State	State of Mary	land / Depa	artment o	f Health and N		iene <sub>19. No.</sub> 20 (	04 037	52
		1	Registrar  . Decedent's Name (First, Middle, Last)			incate (	Doui!	2. Date of Deat	h	3. Time of De	ath
Phys	sicia							Month February		04 11:15H	P.M
	edica		Regina L. Tracey  a. Facility Name (If not institution, give str	root and number)		4b. City. Tow	m, or Location of Death	rebruar	4c. County of		
Exa	mine	r "		eet and manneon,		Balti			N/A		
		5	21 Sorrento Ave.  i. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Fo	oreign
Fune Direct				M 2⊠F	76 Yrs.	Months Da	ys Hours Min.	(Month, Day, 09/25/1	927	MD	
4			Jsuel Residence of Decedent							Lod to side City	- Innian
yland	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23e or 28e-f show snt, it e Medical Examinational be notified at		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City L 1 🗖 Yes 2 [	
Mar B-f st		Š	MD N/A		Balti	more					
ith the Marylan or 28a-f show		ě	10e. Street and Number			10f. Zip Coo	de	11	0g. Citizen of Wh	at Country?	
th wi		- a	21 Sorrento Ave.				21229		USA	A / Andina	
in a first in the Maryla siled within 72 hours after death with the Maryla I Hygiene.		Funeral Director	11. Marital Status	<ol><li>Was Decedent Ever Armed Forces?</li></ol>	in U.S. 13.	Was Decedent If Yes, specify (	ol Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes of No- Rican, etc.)		American Indian, White, etc.	
afte o		7	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 Yes 2 🔀	No Specify:		Specify:	7.71f	4
nours ural!,		d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	160 Door	dent's Usual O	acupation.	1	16b. Kind of Busi	Whi	te
72 h		Completed	15. Decedent's Educa (Specify only highest grade	co <i>mpleted)</i>	(Give	kind of work d DO NOT use re	one during most of worl		TOD. TAILO OF DOOR	niosa niosotry	
in the first		m D	Elementary/Secondary (0-12)	College (1-4or 5+)					Own Hon		
filed with Hygiene.			12 17. Father's Name (First, Middle, Last)			lomemake		ne (First, Middle, I			
ntal h		m					Fllon	Winifre	d Walch		
2 should be f and Mental H		၉	Thomas W. Summers  19a. Informant's Name/Relationship (Typ	e Print)	19b. Maili	na Address (St	reet and Number or Ru			tate, Zip Code)	
d 2 should be fill the and Mental H; 7 is marked others						3		ltimore.			
1 C, Mal y latter A L L  1 and 2 should be filed withi  1 Health and Mental Hygiene.  1 item 27 is marked other then		-	Patricia Roescher/ 20a. Method of Disposition		Ob Place of Dispo	S Alleti osition (Name o	of			ity or Town, State	
in it of it	5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	-	matory or other		0/200/	Doltima	owo MD	
permit. Pages 1 and Department of Heali Important: If item 2	din.	-	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature 9 Funeral Service License</li></ul>				Cemetry02/1		Baltimo		
Dartillo	DDC8		21. Signature di Funeral Service Liberty		5	terling	ddress of Facility g Ashton Sc ondson Ave.	hwab Fun	eral Hon	ne, Inc.	
402			23a. Pary. Enter the disease, or complic	ations that caused the						Approximate	
			shock, or heart failure. List only on	e cause on each line.				, , , , , , , , , , , , , , , , , , , ,		Interval Betwee	ath
Physic			Immediate Cause (Final disease or condition	Cerebrou	Asoolar	Accord	eur			1-240	cent-
/Medi Exami		1	resulting in death)  Due to (or as a consequence of):								
LAdilli		_	Sequentially list conditions, b.	Due to (or as a co	nesionarina offi						
<b>g</b> :	SIL	ine	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a co	meduanca cry.						
I HECOTGS, P.O. BOX 68/60,  The law requires that the death certificate be executed ate has been signed by the attending physician and	-tran	Examiner	that initiated events c. resulting in death) Last	C. Due to (or as a consequence of):							
ate be ex hysician	ouria				,						
physicate	l le	dicai	d								
BOX 6 leath certific attending p	98	Physician/Med	IF FEMALE:	Sc. If yes, outcome of p	regnancy				23d. Date	of delivery	
<b>BOX</b> eath cer	or us	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐Ectopic pregr ☐ Other (speci			Mont		ar
by the a	ped 1	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	e or death 5	_ Other (speci	.,,				
tat b	letac		Part II. Other significant conditions con	tributing to death but n	ot resulting in the	underlying caus	se given in Part I.	23e. Did to	bacco use contrit	bute to the cause of dea	ath?
cords, P w requires that been signed b	pe	by	Hyperteurine Arterios					1 🗆 Y	es 2□No	3 ☐ Probably 4 ☐ Uni	known
Hecords, he law requires to has been signed.	one	ted	Children or I in the		10,100			04- 145-	245 144	ere autopsy findings av	(ailable
e law	CI I	Completed	Diasetes					24a. Was a autop perfor	sv pr	ior to completion of causath?	ise of
ate The	pag	So	Demouria			,			2⊞No 1	☐Yes 2☐No	
VITAL PINGLIAN IN INCOMINE THE CONTINUES OF THE CONTINUES	ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						-	
Physic this c	dire	၉	1 Yes 2 Pro		ent 3 DOA		Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
On C ding P After t	nera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injury		Injury at Work?	280. Describe ii	ow injury occurre		
SIO tendi or: A	the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		A) b = (==== =	M	1 □ Yes 2 □ No	200 Leasting (Otract and Number of Pum I Pouts Number		er	
DIVISION Of VITAL  I or Attending Physician:  after death.  Director: After this certifica	n by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)				mice	City or Tow	Location (Street and Number or Rural Route Number, City or Town, State)		
UIVISION Of VITAI  the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica	completely filled in by the funeral director, page				- to a state of	Ab	No. 100 data	and due to the		anor as stated	
Hosp 4 hou	ely fi	ical	(Check only 2 Medical Exemit	ner: On the basis of ex	amination and/or i	ith occurred at nvestigation, in	the time, date and place my opinion, death occu	e, and due to the our arred at the time, o	ause(s) and mar date and place, a	nd due to the cause(s)	
To the Hospital within 24 hours a	nplet	Medical	one)	and manner stated	1.	29c I	icense number		29d. Date signed	(Month, Day, Year)	
5 45	cor	-	29b. Signature and title of certifier	man A		1	19667		02.09		
	Λ		N Cillare Sher	0-					-		
	11		30. Name and address of person who co		h (Item 23a) (Type	Print)	choway # 57	S Cloud	Sounde of Co	ryland 2106	>
	/		Jeiloel Julia	- 6	Signatura	0	, 0 3,		210-1	-	
	Sta		31. Date filed (Mark Pay, Yel) 200	3. Registrar's	Signarure	sele.					

		•	1 - For State RegistraAmend Item #5	State of Marylan per fh G828			Mental Hygier	/ 11114	03753
	Physici /Medio Examir	ai	Decedent's Name (First, Middle, Last)     FORREST CAS     4a. Facility Name (If not institution, give s	PER TAY		ity, Town, or Location of De	FEBRUAR)	Day Year 1 L 2004	
	Funeral Director	el ō	BALTIMORE REHABILITA 57 900 jal Berusian Hunspaper 6. Sex	TIDD EXTENDED  7. Age (In yrs.		der 1 Year If Under 24 F is Days Hours M			hplace (State or Foreign cuntry)
	a-f show	ctor	10a. State 10b. County  Nay Marks Balfi		ty, Town or Location	w			10d. Inside City Limits
36	s 1 and 2 should be filed within 72 hours after death with the Marylend of Heelint and Meelint Hygiene.  If Heelint and Meelint Hygiene.  Other traumatic event, the Medical Examinar must be notified at	by Funeral Directo	10e. Street and Number  3807 ByfiEld  11. Marital Status  1 Never Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1237'es 2 U No Karr If Yes, Give	I.S. 13. Was De If Yes, s	Zip Code  2007  cedent of Hispanic Origin? pecify Cuban, Mexican, Pu  2008  2008  Specify:		14. Race - Ame Black, White	nican Indian, e, etc.
2121	filed within 72 hour Hygiene. other than "natural" ent, the Medical Ex	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  Grade  17. Father's Name (First, Middle, Last)		16a. Decedent's U (Give kind of life. DO NOT	work done during most of v Juse retired)	vorking 16b.		Industry  Industry
Maryland	should be and Mental I is marked of aumatic even	To Be	FORTEST AIUAT 19a. Informant's Name/Relationship (Type		19b. Mailing Addre	SADIE  ass (Street and Number or	COR NISH  Rural Route Number City	v or Town, State, 2	Tip Code)
Baltimore, Ma	0 0 = 5		TESTIC TRY OR  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	3807 B Place of Disposition (Remetery, crematory)	are of or other place)	112180	Location - City or	
Baltin	permit. Peg Department Importent: I any injury o		21. Signature of Funeral Service License	1	22. Name 52 (13) 12 A1 A1	and Address of Facility			
	Physician /Medical		23a. Part1. Enter the disease, or complications shock of heart fature. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line.  COLON  Due to (or as a consequence)	CANCE	-	iac or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	physicien and physicien and sthe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq					
P.O. Box 687	ath certif ittending or use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of deli	ivery Day Year
	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions con EN TERU - CUTANE			g cause given in Part I.	23e. Did tobacc		the cause of death?
al Records,	: The law re cate has be page 2 sho	Completed by	METASTATIC CA	NCER			24a. Was an autopsy performed 1 Yes 2 X	prior to death?	topsy findings available completion of cause of
ion of Vital	nding Physicien: The th. :: After this certificate his s funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	Other	Heath (Check only one) Home 5 Residence 28d. Describe how in		cify)
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After of mpletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	nome, farm, street, fact fy)	tory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	iral Route Number,
	To the Hospital or within 24 hours after to the Funerel Dir completely filled in	Medical	29a. Certifier 1	icien: To the best of my knower: On the basis of examina and manner stated.	owledge, death occurration and/or investigati	ed at the time, date and plation, in my opinion, death or	curred at the time, date a	and place, and due	to the cause(s)
	9 1 1 1 1	Σ	29b. Signature and title of certifier	Tan, W	· A.	29c. License number 14958	G	Date signed (Month)	6, 2004
	0		30. Name and address of person who co	mpleted cause of death (Iter 2003 32: Registrar's Signa	H RAVEN	POULEVAR	BALTIMO	$(\mathcal{E}, \mathcal{V}_0)$	21218
	Sta Regist	ate rar	FED 1 0 2004	Estate La	1 South		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** THELMA TAYLOR 0 000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5. Social Security Number N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. DEC. 1, 1919 9. Birthplace (State or Foreign 6. Sex 7. Age **Funeral** 1 🗆 M 84 MARYLAND 215 16 7789 Director Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County ortant: If itam 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No N/A BALTIMORE Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22-30 ATHOL AVE. 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry laryland 2121 Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) UNK UNKNOWN UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental SAMUEL TAYLOR MATTIE BEASLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If itsm 27 is any injury or other traus. CHERICE WINKLER(great niece) 2212 CLOVILLE AVE. BALTO, MD. 21214 Baltimore, 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEM. FEB. 11,2004 BALTIMORE, MD. 21. Signature of Funerat Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET. BALTO, MD. 21213 1412 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** da /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attanc within 24 hours after death To the Funaral Diractor: 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier asanthalamer. 166 42510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genera M.VASANTKA-KUMALNID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2004 Registrar

			1 - For State Registrar	te of Maryland		artmen rtificate			and M		giene Reg. No.	004	03755
1	Physici	an	1. Decedent's Name (First, Middle, Last)	Tyler						2. Date of De Month	Day	Yeer	3. Time of Death
	/Medie Examir		4a. Fecility Name (If not institution, give street a North West Hospi	nd number)		0.	Town, or	Location o	of Deeth	repruar	4c. Co	2009 Dunty of Deeth Baltimo	
,	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	ff Under Months	1 Year Days	ff Under : Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	y, Year)	9. Birthp	lace (State or Foreign
	Director		220-03-8813 Usuel Residence of Decedent	84	115.					July 23	,1919		MD
	arylan show	L	10a. State 10b. County	10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	the Mg	ecto	MD Baltimore  10e. Street and Number	Ow	ings N	T	0 1				40. 000	(117	1 ☐ Yes 2X No
	Sa or	ī	4 Beth Court			10f. Zip	211	17				n of What Cour	itry?
	death	Funeral Director	11 Marital Status 12. Wa	s Decedent Ever in U.S red Forces?	. 13. \	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		Race - Americ	
36	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 show alcal Examiliac must be notified at	y Fu	1 Never Married 2 Married 1	Yes 2 XNo es, Give		1 ☐ Yes :		Specify:	, rueito	ricali, etc.)		Black, White,	
5-0036	2 hour	Completed by	15. Decedent's Education	ar or Dates:	16a. Deced	dent's Usua	I Occupa	tion			16b. Kind	Whi of Business/Ind	
21215	within 7. ene. then "n	nple	(Specify only highest grade compa	leted) lege (1-4or 5+)	(Give life. L	kind of wor DO NOT us	k done d e retired)	uring most	of work	ng			,
121	filed with Hygiene. Ither the	Cor	12 17. Father's Name (First, Middle, Last)		Se	ecreta	ary	10 Methe	da Nama	(First, Middle.		Office	
and	d be f ental } ked of	To Be	George Jankowski							Holmes	Maigen Su	mame)	
Maryland	2 should be is and Mental I is marked or aumatic eve	-	19a. Informant's Name/Retationship (Type, Prin	nt)	19b. Mailin	ng Address	(Street a			I Route Numbe	or, City or To	own, State, Zip	Code)
-	and 2 lealth m 27 i			ughter				Owin		ills, M			
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iteme 23s or 28s-1 show many hours or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 ₩ Burial 2 □ Cremation 3 □ Removal	from State cen	ce of Dispo netery, cren	natory or of	her place			ate / O /		ion - City or To	
altin	permit. Pag Department Important: I eny Injury c		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Cre	stlawı 22	n Ceme			2/11			ottsvil erstown	
ä	Depa impo eny it		Fans & Ch	22	E	line 1	Fune	ral H	ome	Reiste			21136
8760,	Physician /Medical Examiner  populari-transit	cal Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	untiple on each line.  untiple oue to (or at a consequence to (or as a consequence to (or a) (	organ		item	^	llur Don	ಲ	nest,	1e 4	Approximate Internat Between Onset and Death U.Y. hours
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	es, outcome of pregnand Live birth 2 Tetal d Pregnant at time of dea Unknown	eath 3	Ectopic pre					23d	. Date of delive Month	ry Day Year
	signed to det	d by P	Part II. Other significant conditions contribution Type T dichetes med	g to death but not result	ing in the ur	kidn	1	n in Part I.	,		bacco use es 2□N	1	e cause of death?
cor	s been s shou	oiete	Chronic obstructives	pulmonary	disc	ase	1			24a. Was	an 2		osy findings available
Division of Vital Records,	rsician: The law s certificate has b lirector, page 2 s	Completed by	Hypethyroidism // V		rdion		thy	/			med! 2 ☑ No	death?	npletion of cause of 2□ No
× ×	Physician: r this certifica ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	1 npatient 2 E	P/Outpatien	t 3 DO	Othe	~		_(Check only on ne 5 ☐ Resid		10th == (Ct	1
n of	ding Phys h. After this funeral dii		27. Man er of Death 28a. 1 Natural 5 Pending		8b. Time of fnjury		Bc. fnjury Work			28d. Describe h			<i>)</i>
/isio	Attendidate: death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At hom	e, farm, stre	М	1 🗆 Y	es 2 🗆 N		28f. Location (S	Treet and N	umber or Rural	Route Number.
Ö	tal or is after al Dire	Certi	4 Homicide determined 206.	building, etc. (Specify)	.,	,	5.1100			City or Tow		or trorar	Troute Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 W Certifying Physician: 2 Medicet Examiner: On and	To the best of my knowl the basis of examinatio I manner stated.	edge, death n and/or inv	occurred a	it the time	o, date and nion, death	i place, a	and due to the dead at the time, o	ause(s) and late and pla	d manner as sta ce, and due to	ated. the cause(s)
	To the To the comp	W	29b. Signature and title of certifier	$\cap$		1	License		1			gned (Month, L	•
,	3)		y judicoru M		10-1-7		100	462	)	f	ebrud	ary 8,	2004
	W/		30. Name and address of person who completed 3 Boston North	want II.	(Type, I	Print) Ce	nte	r R	ann	lalisto	un.	Maryla	nd 21133
~	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 0 2004	32. Registrar's Signatur		P			3. 1, 7 0		)	, , , , , ,	

		•	State of Maryland / Dep	partment of Health and Nertificate of Death		e 2001, 02750
/M	sician edical miner	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give st	0	4b. City, Town, or Location of Death	2. Date of Death Month D	lay Yeer 3. Time of Death 2004 / S/PM Ic. County of Deeth
Fune Direc		5. Social Security Number 6. Sex	Or al 7. Age (In yrs. last birthda) M 2 MF	(1) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
13-UU30 72 hours efter deeth with the Maryland "natural", or Iteme 23a or 28a-f show	ted by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:  16a. Dec	10f. Zip Code  2/2/4  . Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	10d. Inside City Limits  1  Yes 2 N6  Citizen of What Country?  14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry
laryland 212 2 should be filed within and Mental Hygiene. Is marked other then	Ве Сотр	(Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  19a, Informant's Name/Relationship (Typ	College (1-4or 5+)  Given by the complete of the college (1-4or 5+)  Given by the college of the	re kind of work done during most of work DO NOT use retired)	ing SA/S7 e (First, Middle, Maid	or Town, State, Zip Code)
Department of Health Important: If item 27		20a. Method of Disposition  1 Parial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	moval from State Constant, or	emalory or other place)  A FOREST  22. Name and Address of Facility  A COLLY KO  A COLLY K	0.04 De oga C. Gre anda115 tou	Location · City or Town, State  Dings Mills MD  Location · City or Town, State  Dings Mills MD  Location · City or Town, State
death certificate be executed  We will be executed  How many sides and death of the control of t	cal Examiner	23a. Part 1. Enter the risease, or complic shock, or hearn ailure. List only one firmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of):	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
the death certificate by the attending physical	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
Hecords, 1 The law requires the	completed by	1/1/06 SIPST		7 A Stend		
On of	o Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year)  28b. Time Injury	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
DIVI Hospitel or At 24 hours after o Funeral Direct	Medical Certifi	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)  ician: To the best of my knowledge, deer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	City or Town, Sta	(s) and manner as stated.
To the within 7	,	29b. Signature and title of certifier  30. Name and address of person who con	-pep.	29c. License number  DO05786		Date signed (Month, Day, Year)  2/:/04  2///04  2///04
Re	State gistrar	31. Date filed (Month Day Year) 2004	32. Registrar's Signature	munorial He	spital/18	altimere MDZ(218

DHMH 17 Rev 1/2001

	1	For State Registrar	State of Maryland	I / Department of F Certificate of			ene . No. 20(	14 0379
Physician /Medical	1	Decedent's Name (First, Middle, Last)	Willia	um S		2. Date of Death Month	Day Yea	3. Time of Death
Examiner  Funeral Director	5	112-20.0109	treet and number)  Lursing 14	me BAC+	r Location of Death  MOC  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of De	Birthplace (State or Foreign Country)
Department of health and Mental Hygene. Important: if item 27 is marked other than "naturel; or itema 23a or 28a-1 show important: if item 27 is marked other than "naturel; or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Executive Internal Residual and Since Internal Director To Re Completed by Finnersi Director	by runeral Director	Journal Residence of Decedent  10a. State  10b. County  10e. Street and Number  3406 CC/is/e  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	10c. City.  2. Was Decedent Ever in U.S. Armed Forces? 1  Yes. 2 No If Yes. Give Year or Dates:	Town or Location  A ( /, M ) ( e ) 10f. Zip Code			14. Race - Al Black, W	merican Indian,
yglene. her than "nature nt, me Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing 16	Hear My	ss/Industry
arked ott atic even	ă	JOHN SNE	ad		Bes	Sie F	Praxt	
Department of Health and Important: If item 27 is many injury or other traum once.		19a. Informant's Name/Relationship (Type)  20a. Method of Disposition  1	S Oaughter 20b. Plice ce amoval from State	19b. Mailing Address (Street  3 40 7 Ca / / ace of Disposition (Name of metery, crematory or other plan  22. Name and Addres  22. Vame and Addres	s/e Aug 2-10	Date 20 -04 (20 -04 (20)	nore mi c. Location - City DALYIMO	0 2/2/6 or Town, State of e M D end Secures
ysician Medical April 1 April	Examiner	23a. Part1. Enter me disease, or complishock, or head failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	rebrul va ence of):	ng, such as cardiac		ext	Approximate Interval Between Ginger and Death
	Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy	,		23d. Date of o	delivery Day Year
n signed by	<u>ה</u>	Part II. Other significant complitions con	tributing to death but not resu	lting in the underlying cause gro	ren in Part I.	23e. Did tobac		to the cause of death
page 2 shor	Сощрієте	(types	lenson			24a. Was an autopsy performe	di death	autopsy findings availa to completion of cause ? es 2 \square No
rector,	e n	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospit <b>a</b> l: 1 □ Inpatient 2 □ E	ER/Outpatient 3 DOA Oth	100	h (Check only one)	2 Floring (2	
is after death.  al Director: After this certificate has ed in by the funeral director, page 2  Certification: To Be Common		27. Mannarof Death  1 Natural  2 Accident  3 Suicide  4 Homicide  5 Pending investigation  6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Mo	y at	ome 5 ☐ Residence 28d. Describe how 28f. Location (Street City or Town, \$	injury occurred	Rural Route Number,
in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)  29 Medical Examir 29b. Signature and title of certifier	sician: To the best of my knowner: On the basis of examination and manner stated	viedge, death occurred at the fin ion and/or investigation, in my o	opinion, death occur	red at the time, date	se(s) and manner and place, and d	lue to the cause(s)
M F O		A	T. MI		D2756	9	21570	14
. (		30. Name and address puperson who co	/			1	1 4	1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Physician Edith Mary Whetzel 8:40 AM Feb 2004 Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner University of Maryland Specialty Hospital Baltimore N/A7. Age (In yrs. last birthdey) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) AUG 26, 19 6. Sex Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□M 2√2F 212-26-5284 83 Director 1920 West Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Maryland Baltimore Directo Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2B Merrill Road 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1☐Never Married 2☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be ind Mental Emma Dove John Whetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Whetzel/daughter 2B Merrill Road Catonsville, MD 21228 .nit. Pages 1 e. Jepertment of Her Inportant: if Ite 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Liberty Baptist Cemetery 2/12/04 Lisbon, Mo 22 Name and Address of Fecility
MacNabb Funeral Home, P.A. DW/AS McDonald 301 Frederick Road Dawn F. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical compthomias Cardiac la minnes Examiner Due to (or as a consequence of) Examiner Jeillure Conyestive heaming ed by the attending physician en deteched for use es the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): typertension 1045 Physician/Medical Due to (or as a consequence ol): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Demenhol δ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Denubition clears 14 Yes 24 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Hospital: 1 □ npatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No within 24 hours effer death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Division ( 5 Pending investigation 1 Naturel 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 304194 218/2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gel swith charles st University speed liny Balhmare MD & K30 hesplan!

Registrar DHMH 16 Rev 6/95

State

KNESAIM

31. Date filed (Month Bay, 1'00) 2004

32. Registrar's Signary

an	Registrar			Cel	uncate	of Death			jiene eg. No. 2	UUL	03/5
an	1. Decedent's Name (First, Middle, L	ast)					1	2. Date of Dea Month	th Day	Year	3. Time of Death
cal	Edwa			ndler				Februa		2004	3:40 P
er	4a. Fecility Name (If not institution, g					own, or Location of				ty of Death	
	Eastpoint Nursin	ig & Re		. last birthday)	Ea If Under 1	astpoint		3. Date of Birth			ce Co.
	5. Social Security Number 212-16-6493 6.	1( <b>3</b> tM 2□		Yrs.		Days Hours	Min.	(Month, Day March	, Year)		place (State or Foreign ntry) ryland
	Usual Residence of Decedent  10a, State 10b, County		10c. C	ity, Town or Lo	ocation					1	IOd. Inside City Limits
5	102.0.2.		100.0	,,			n 1	1. 2	Q:+		1 ☑ Yes 2 ☐ No
Directo	Maryland  10e, Street and Number	N/A			10f. Zip C	code	Ват	timore	10g. Citizen of	f What Cour	ntry?
	3501 St. Paul	Street	Apt. 1	.045		2121	8		Unite	d Stat	tes
Funeral	11. Marital Status	12. Was (	Decedent Ever in	U.S. 13.	Was Deceder	nt of Hispanic Ori y Cuban, Mexican	gin? (Spec	ify Yes or No-	14. Ra	ace - Americ	
	1 Never Married 2 Married	I 1⊠Y If Yes	d Forces? ′es 2 ☐ No ., Give		1 ☐ Yes 25			ioari, otc.)	Spec	ifv:	
d by	3 Widowed 4 Divorced	Year	or Dates: W	WII		A			10h Kind of		nite
Completed	15. Decedent's (Specify only highest of	Education grade complet	ted)	16a. Dece (Give	dent's Usual ( kind of work DO NOT use	Occupation done during mos retired)	t of working	9	16b. Kind of	Business/in	dustry
dm	Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)		akeman				Rail	road	
ပိ	17. Father's Name (First, Middle, La	st)				18. Mothe	r's Name	(First, Middle,			
To Bo	Paul Wendler					Ag	nes M	. Yin	gling		
-	19a. Informant's Name/Relationship					Street and Number					
	Mrs. Ida M. Brow	m (Sis	ter)	7724	1 North	h Point	Road	Edgem	ere, Ma	arylar	nd 21219
	20a. Method of Disposition 1 Burial 2 Cremation 3	□ Bomoval f		Place of Dispo cemetery, cre	osition (Name matory or oth	e of ner place)	Da	ite	20c. Location	n - City or To	own, State
	4 Donation 5 Other (Special Control of Special Cont		H	illtop	Servi	ce Corp	2/12	/2004	Tows	on, Ma	aryland
	21. Signature of Funeral Service Lic	:00 <del>00</del>	1	00	Name and uda-Ru	Address of Facility	ral H	ome of	Dunda	lk, Ir	nc.
10	1)		Can	ull	7922 W:	ise Ave.	Dun	dalk,	Marylar		222
	29a. Part . Enter the disease, or co shock, or heart failure. List on	inplications to by one cause	on each line.		ter the mode	of dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	V	entric	eles	tru	mythr	ME			,	min s
	resulting in death)	Du	e to (or as a conse					1		0:1	
L	Sequentially list conditions, if any, leading to immediate	b. HY	to (or as a conse		hess:	scleochi	L am	SHO VO	new	1)1812	e syr
Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, ,	to (or as a consi	equence or).							
Examin	that initiated events resulting in death) Last	c. Du	e to (or as a conse	equence of):							
ш											
cal		d									
cal			s, outcome of preg						23d. [	Date of deliv	ery
ca		1 🗆 L 4 🗆 P	ive birth 2 Fe Pregnant at time of	tal death 3	□Ectopic pre					Date of deliv	ery Day Year
cal		1 🗆 L 4 🗆 P	ive birth 2 Fe	tal death 3							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ L 4 □ F 9 □ L	ive birth 2   Fe Pregnant at time of Unknown	stal death 31 death 51	Other (spec	city)	ı.		obacco use co	Month ontribute to t	Day Year the cause of death?
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	1 □ L 4 □ F 9 □ L	ive birth 2   Fe Pregnant at time of Unknown	stal death 31 death 51	Other (spec	city)	l.	23e. Did to	obacco use co	Month ontribute to t	Day Year the cause of death?
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	1 □ L 4 □ F 9 □ L	ive birth 2   Fe Pregnant at time of Unknown	stal death 31 death 51	Other (spec	city)	l.	1 🗆 1	obacco use co (es 2 No an 24t	ontribute to to 3 Prof	Day Year the cause of death? bably 4 Unknow
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	1 □ L 4 □ F 9 □ L	ive birth 2   Fe Pregnant at time of Unknown	stal death 31 death 51	Other (spec	city)	l.	1 🗆 1	obacco use co ves 2 No an 24b	ontribute to to the state of th	Day Year the cause of death? bably 4 Unknow
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	1 DL 4 P 9 DL s contributing	ive birth 2   Fe Pregnant at time of Unknown	stal death 31 death 51	Other (spec	use given in Part l		1 Nas	obacco use co yes 22 No an 24th ssy made 2	ontribute to to the state of th	Day Year the cause of death? bably 4 Unknow opsy findings availabl ompletion of cause of
o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 DL 4 P 9 DL s contributing	ive birth 2 Fe Pregnant at time of Jnknown to death but not re	esulting in the s	Other (special or other special or other	use given in Part	e of Death ursing Hom	24a. Was autor perfo	obacco use co yes 22 No an 24t ssy made 22 No an 24t 24 No an 24t 24 No	ontribute to to a great of the second of the	the cause of death? bably 4 Unknow oppy findings available of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 DL 4 PF 9 DL s contributing Hospital:	ive birth 2 Fe Pregnant at time of Jnknown	esulting in the i	Other (special underlying cau	26. Plact  Other: No. Injury at Work?	e of Death ursing Hom 2	24a. Was autop perfo	obacco use co yes 22 No an 24t ssy made 22 No an 24t 24 No an 24t 24 No	ontribute to to a superior to eccept a late of the contribute of t	Day Year the cause of death? bably 4 Unknow oppy findings availab ompletion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1   1   1   4   F   9   1   1   1   1   1   1   1   1   1	ive birth 2 Fergrand at time of Jnknown  I to death but not receive to	esulting in the selection of the selecti	Other (special order) of 28	26. Place  A Other: No Work?  1 □ Yes 2 □	e of Death ursing Hom 2	24a. Was autor perio 1 Yes (Check only of the 5 Resided Bd. Describe h	obacco use co yes 22 No an 24b isy irred ? 22 No oberos 6 □ C now injury occ	ontribute to to the state of th	Day Year the cause of death? bably 4 □Unknow opsy findings availabl ampletion of cause of 2 □ No
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1   1   1   4   F   9   1   1   1   1   1   1   1   1   1	ive birth 2 Fergrand at time of Johnsown  to death but not of the service of the	esulting in the selection of the selecti	Other (special order) of 28	26. Place  A Other: No Work?  1 □ Yes 2 □	e of Death ursing Hom 2	24a. Was autor perio 1 Yes (Check only of the 5 Resided Bd. Describe h	obacco use co	ontribute to to the state of th	the cause of death? bably 4 Unknown oppy findings available of cause of
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Hospital:  28a. [  28e. [	ive birth 2 Feregrant at time of Jnknown  I to death but not represent the service of Injury (Month, Day Year)  Place of Injury - At building, etc. (Spe	esulting in the sesulting in the session in the	Other (special continuous continu	26. Plact  Other: No Work? 1 Yes 2	e of Death ursing Hom 2	24a. Was autor period 1 Yes (Check only of the 5 Resided Bd. Describe for the control of the con	obacco use co	ontribute to t  3 Prol  b. Were autr prior to cc death? 1 Yes  Other (Speci	Day Year the cause of death? bably 4 Unknown oppy findings availabl ompletion of cause of 2 No
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Hospital:  28a. [ Physicien: Txaminer: On	ive birth 2 Fergrant at time of Jnknown  I to death but not represent the second of th	esulting in the selection of the selecti	Other (special or other special or other	26. Place  26. Place  Other: No.  C. Injury at Work?  1  Yes 2  office	e of Death ursing Hom 2	24a. Was autoperformed of the control of the contro	obacco use cover 22 No an 24t an 24t 22 No one) dence 6 00 one injury occ Street and Nur vn, State)	ontribute to to a superior to or death?  Other (Special curred)	Day Year the cause of death? bably 4  Unknown opsy findings availablompletion of cause of 2  No  (fy)  Tal Route Number,
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Hospital:  28a. [ Physicien: Txaminer: On	ive birth 2 Feregrant at time of Jnknown  I to death but not represent the second of t	esulting in the selection of the selecti	ont 3 DOA  of 28  M treet, factory,	26. Place  26. Place  Other: No.  C. Injury at Work?  1  Yes 2  office	e of Death ursing Hom 2	24a. Was autor period 1 Yes (Check only of the 5 Resided Reserved	obacco use cover 22 No an 24t an 24t 22 No one) dence 6 00 one injury occ Street and Nur vn, State)	ontribute to I  3 Prol  b. Were autresser of contribute to or death? 1 Yes  Other (Special coursed course c	the cause of death?  bably 4 Unknown  opsy findings availably  mpletion of cause of  2 No  fly)  al Route Number,  stated,  to the cause(s)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Hospital:  28a. [ Physicien: Txaminer: On	ive birth 2 Fergrant at time of Jnknown  I to death but not represent the second of th	esulting in the selection of the selecti	ont 3 DOA of 28 M treet, factory,	26. Place A Other: No Work? 1 Yes 2 Office	e of Death ursing Hom 2	24a. Was autopento 1 Yes  (Check only one 5 Resided Bd. Describe to City or Town and due to the digital at the time,	obacco use co yes 22 No  an 24t  ssy med? 22 No  dence 6 Co now injury occ  Street and Nur vn, State)  cause(s) and date and place  29d. Date sig	ontribute to to a superior to or death?  Other (Special Surred Su	the cause of death?  bably 4  Unknown  opsy findings available  oppletion of cause of  2  No  ffy)  al Route Number,  stated.  to the cause(s)  Day, Year)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Hospital:  Hospital:  28a. [ Physicien: Txaminer: On and	ive birth 2 Feregrant at time of Jnknown  I to death but not represent the second of t	DER/Outpatie  28b. Time Injury  home, farm, s cify)	ont 3 DOA of 28 M treet, factory, with occurred a nocstigation, i	26. Place A Other: Nother: Not	e of Death ursing Hom 2	24a. Was autopento 1 Yes  (Check only one 5 Resided Bd. Describe to City or Town and due to the digital at the time,	obacco use co /es 2 No  an 24t  ssy med? No  dence 6 0  conow injury occ  Street and Nur  vn, State)  cause(s) and date and place	ontribute to to a superior to or death?  Other (Special Surred Su	the cause of death?  bably 4  Unknown  opsy findings available  oppletion of cause of  2  No  ffy)  al Route Number,  stated.  to the cause(s)  Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State	of Marylar		partment o	f Health and		giene	2006	03761
- all	E.		Registrar  1. Decedent's Name (First, Mid-	dle, Last)			- Timoate (	or Death	2. Date of Dea	-	Jun (0 () 1	3. Time of Death
	Physici			7		We	resser	5.02	Month	Day	My Zau	2:470AM
	/Medic	100	4a. Facility Name (If not instituti	on, give street and n	um <i>ber</i> )	0000		m, or Location of Dea	1-Chruar		County of Death	
	Examin	er	Nathwest	1.1	1, 1-		1				altima	
100 S	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	y) If Under 1 Y		s. 8. Date of Birti	1	9. Birth	place (State or Foreign
100	Qirector		218-12-8346	X□M 2□F	79	Yrs.	Months Da	ays Hours Min	May 21,		- 1	vland
P	-		Usual Residence of Decedent									
ırylar	show E	L	MD Ba	l <b>timore</b>		ty, Town or I altimo						10d. Inside City Limits  1 Yes XXNo
9 W	89-f	cto				arcriic						
Aith ti	nor2	급	10e. Street and Number	Dood			10f. Zip Co				en of What Cou	untry?
-0036 hours after death with the Maryland	nd Mental Hygiene. marked othar than "natural", or Itams 23a or 28e-f show imatic event, the Mudical Examinat must be notified at	Funeral Director	2927 Rolling		anders Ever in 11	10 110	212		Const. Vac as No.		S. A.	ieen ladien
er de	lten.	nue	11. Marital Status  1 □ Never Married 2 □ Ma	Amped F	cedent Ever in U Forces? : 2 □ No	1.5.	If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue	sto Rican, etc.)	'	Black, White	
Is aff	1, 0,	by F	3 X Widowed 4 □ Divorce	If Voe G		г	1 ☐ Yes 2 🗶	No Specify:			Specity: Wh:	ite
<b>ج</b> ڏ	E Stur	ed	15. Decede	ent's Education		16a. Dec	edent's Usual O			16b. Kin	d of Business/fr	ndustry
-6121: within 72	O Water	ple	(Specify only high Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Giv	e kind of work di DO NOT use re	one during most of w etired)	orkin g			
<b>21215-0036</b> d within 72 hours af	tree the	Completed	7	Ö	(1-401 3+)	Ti	le Sett	er		Con	structi	on
ਰ 🚆	othar vent, I	ВеС	17. Father's Name (First, Middle					18. Mother's N	ame (First, Middle,	Maiden S	Su <i>ma</i> me)	
/lan	Menta rked tlc e	ToE	Harry	Weckes	ser			Tilli	ie I	Heck		
<b>1ar,</b> 2 sho	if Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mai	iling Address (St	reet and Number or F	Ru <i>ral R</i> oute Numbe	r, City or	Town, State, Zi	ip Code)
	alth 27 I		Jerry L. Wecke	sser	Son	183	Sara La	ne, Hanove	er. Penns	v1 vai	nia 1731	31
altimore, mit. Pages 1 at	of Hear filtern rothe		20a. Method of Disposition	2 Pomoval from		Place of Disp cemetery, cr	position (Name of ematory or other	f place)	Date	20c. Loc	ation - City or T	own, State
Pages	nent ant: Il ary o		`4 □Donation 5 □Other		Lo		Park		1/04	lood	lawn, Mar	ryland 21207
	Depertment of Important: If I sny Injury or once.		21. Signature & Funeral Service	e Licensee			22. Name and A	ddress of Facility	ring Rya	re Fr	unoral I	Directors In
m a	ã E <b>≅ 3</b>		Chest Blu	we		8	728 Lib	erty Road,	Randalle	LOWN	MD 211	01rectors in 133_4784
91			23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the deat	th. Do not e	nter the mode of	dying, such as cardi	ac or respiratory an	est,	, 21.	Approximate Interval Between
Ph	ysician	ŀ	Immediate Cause (Final disease or condition			Kid.						Onset and Death
//	Medical		resulting in death)	a. Due to	o (or as a conseq							days
E	caminer		Conversion to the secondations	h								
A. T.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conseq	uence ol):						
760, le be executed	hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	С								
760, e be exe	ien a		resulting in death) Last	Due to	o (or as a conseq	quence of):						
	hysic the bi	Ilcai		d								
. Box 68 death certifica	attending phy	Physician/Med	IF FEMALE:									
. Box	ed by the attendin detached for use	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Feta	al death 3	□Ectopic pregn			2.	3d. Date of delive Month	very Day Year
O. E	the all	SICI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□ Unk	gnant at time of c nown	death 5	Other (specify	v)			MORE	Day 16a1
at the	d by letach	P.		tions and the single	dansh b				OO+ Dide			
Records, P.O The law requires that the	50	۾	Part II. Other significant condi	_		_	, ,					the cause of death?
or or	been si should l	eted								95 ZL	110 3 110	bably 4 Nunknown
Records,		Completed	Preumoni	۵					24a. Was a autop:	sy	prior to co	opsy lindings available ompletion of cause of
H 4	oag oa	Con							perfor 1 ☐ Yes		death? 1 ☐ Yes	20 No
Division of Vital or Attending Physician: 1	ns certificate has I director, page 2	Be	25. Was case referred to medic examiner?						eath (Check only or	10)		
Of Shysi	this c	ဥ	1 ☐ Yes 2 No				ent 3 DOA		Home 5 Resid			fy)
ing F	h. After th funeral	ü.	27. Manner of Death 1 Natural 5 ☐ Pend		e of Injury onth, Day Year)	28b. Time Injury		Injury at Work?	28d. Describe h	ow injury	occurred	
Sic	tor: /	Certification:	2 Accident invest 3 Suicide 6 Coul	d not be		<u> </u>		1 ☐ Yes 2 ☐ No				
or At	fter o	E		mined 28e. Plac	ce of Injury - At h Iding, etc. (Special	ome, larm, s fy)	street, factory, of	ice	City or Tow		Number of Run	al Route Number,
Div To the Hospitel or	within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	ပိ	20a Contition	ing Physician T "	he heat of	audade = 3	al .					
HOS	24 hours Funeral etely filled	edical	29a. Certifier 1 Certify (Check only 2 Medic	ring Physician: To the Examiner: On the	he best of my kno basis of examina inner stated.	ation and/or	atn occurred at th investigation, in a	ne time, date and place my opinion, death occ	ce, and due to the courred at the time, o	ause(s) a late and l	and manner as s place, and due t	stated. to the cause(s)
the c	within 2 To the complete	Med	29b. Signature and title of certif		annor stated.		29c. 1 ii	ense number	3	9d. Date	signed (Month,	Day, Year)
ĭ	ž <b>⊢</b> 8		100	1 -								
	5		XXI	49	this	- 00-1 =	1000	156632		Unic	ry 7th	2004
			30. Name and address of person	in who completed cal	O/a / A	п 23а) (Туре	e, Print)	Randalls1	4		1127	
	Sta	to	31. Date liled Month, Day, Xea	HOOM B32.	Registrar's Sions	ature #	TEA	KUNCALLSI	wh me	- ×	1150	
	Registi	100	31. Date liled Month, Day, Xea	ZUU4	MR B.	200	refer.					

			riease	Type or Print				•	_	
	1		For	State of Mar	•	partment of H		Mental Hygle	ene	00760
			State Registrar			ertificate of	Death		. No. 😂 🔾 🔾	00/02
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day (O Year	3. Time of Death
	/Medic			ARREN				FEBRUARY	4c. County of Deat	11:00 M
	Examin		4a. Facility Name (If not institution, give				or Location of Death			
			Northwest Hosp:		In yrs. last birtho	Randall	Stown If Under 24 Hrs.	8. Date of Birth	Baltimo	
П	Funeral		5. Social Security Number 6. S	TMA 2∏F	. V.	Months Days		(Month, Day, Y	9ar) Co	hplace (State or Foreign untry) MD
	Director		215-28-6675 Superior Street St		70 ''			11 28	33	MD
	land ow		10a. State 10b. County	1	IOc. City, Town o	Location				10d. Inside City Limits
	Many if ah	ţō	MD NA		Baltin	ore				1X1Yes 2 □ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	73a o	a D	5006 Levindale	Road		2	1215		U.S.A	
	deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	3. Was Decedent of I	Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
စ္	or Ite		1 ☐ Never Married 2 X Married	1 X Yes 2 □ No If Yes, Give		1 □ Yes <b>3/□</b> (No			C	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						Black
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. wher then "netural", or Items 23s or 28s-f show wit, it is Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	10	ecedent's Usual Occu live kind of work done e. DO NOT use retire	during most of wor	rking	b. Kind of Business/	Industry
2	vithin ne. hen	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	"			h		to College
N	Hygie Hygie Ther t		12th grade  17. Father's Name (First, Middle, Last	na		Supervis		ne (First, Middle, Ma		ate College
anc	ntal H	Be	North Warren	,			Ruby G		,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow amy rigury or other traumatic event, the Medical Examination in the notified at once.	L C	19a. Informant's Name/Relationship (	Type Print)	19b. M	ailing Address (Street	-		City or Town, State, 2	Zip Code)
Na	d 2 sl th an 7 is r					6 Levino				21215
	1 an Heali am 2		Rebecca Warren	-мтт6	20b. Place of D	sposition (Name of			c. Location - City or	
altimore,	ages nt of .: Wit		Waurial 2 ☐ Cremation 3 ☐			crematory or other pla		2/11/04	Outpa M	:11a Ma
뜵	it. Purtme		<ul> <li>4 □Donation 5 □Other (Special</li> <li>21. Signature of Funeral Service Lices</li> </ul>		Garris	on Fores		2/11/04	OWING FI.	LIIS, Mu
Ba	Depariment Department of the series of the s		Je WI			March F/		D-1+:-		21215
	S		23a. Part1. Enter the disease, or com	polications that caused the	ne death. Do not	4300 Wab	Dasn Ave ing, such as cardiad	or respiratory arrest	ore Ma	21215 Approximate
П			shock, or heart failure. List only Immediate Cause (Final	one cause on each line						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		515				
н	Examiner			Due to (or as a	consequence of)	0				
Ĵ		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of)	HC KEN	ABL FB	ILURE		
	ted usit	Examiner	cause. Enter Underlying Cause (Disease or injury	·	-		· mr	WITUS.		
2	be executed ician and buriat-transii	xar	that initiated events resulting in death) Last	c Due to (or as a	consequence of)	JIM 12E IE	2 1116	((1 10>		
760,	be e siciar burit	calE		-						
687	icate phy: s the	ggic		g						
Box (	death certificate e attending phys	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of de	ivery
	atter affor u	Clar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy 		Month	Day Year
P.O.	the c y the achec	lys	9 Unknown	9□ Unknown						
	es that the death certificate be executed igned by the attending physician and be detached for use as the burtat-transit	by Pi	Part II. Other significant conditions	contributing to death but	not resulting in the	ne underlying cause g	iven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
g	quires n sign							1 ☐ Yes	2 No 3 P	obably 4 Unknown
CO	law requires as been sign 2 should be	Completed						24a. Was an	24b. Were au	topsy findings available
Re	9 4 9	m C						autopsy performe		completion of cause of
ta	ician: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 ath (Check only one)	1 101	2/3/10
of Vital Records,	Physician: this certificatal director, it	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital:	t 2 ER/Outp	atient 3 DOA	ther	lome 5 ☐ Residen	ce 6 □Other (Spe	cify)
o	Phys or this oral di		27. Manner of Death	28a. Date of Injury	28b. Tin	ne of 28c. inju		28d. Describe how		- //
Division	Attending Is death. ector: After by the funer	를	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Inju		Yes 2 □No			
VIS.	or Attandi after death. Director: A in by the fu	iffe	3 Suicide 6 Could not I	280. Place of Injul	y - At home, farm	, street, factory, office	9	28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
Ö	al or A s after of Direct	Certification:	4 Homicide	building, etc.	(Opocity)			Jay or rown,		
	e Hospital 24 hours a e Funerel I letely filled	603		hysician: To the best of						
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edica	(Check only 2 ☐ Medical Exa	miner: On the basis of and manner stat		or investigation, in my	opinion, death occi	urred at the time, date	e and place, and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	co - at			nse number	290	d. Date signed (Mont	h, Day, Year)
	1		Johnson K	melta	W.D.	Do	041410	· Fe	brugen 06	12014.
	NOX		30. Name and address of person who	completed cause of de	ath (Item 23a) (T	ype, Print) 15 G 1	NOER P	MEHTA	\$	1
13-4-	10.			Α.	ENTER		LLSTOWN	_mo_	21133	
7.		ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	Small !		-		
	Dogiot	17.7	1 0 20	1117 8570	66.	CONTRACTOR A				

DHMH 17 Rev 1/2001

WARD

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** February 6 2004 6:10 P.M William L. Willett, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 731 Winton Avenue Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 18, 1943 1**√** M 2□ F 216 42 2897 60 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or Itams 23a or 28a-f show 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 731 Winton Avenue 21060 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 □ No If Yes, Give 7/10+ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status iled within 72 hours after 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes, Give Viet Nam Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Use Ma than Elementary/Secondary (0-12) College (1-4or 5+) Domino Sugar Mechanic .. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If itam 27 Is marked other ti jury or other traumatic event, IL. year 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William L. Willett, Sr. Phyllis Leona Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Willett / wife 731 Winton Avenue Glen Burnie, Maryland 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 2/10/2004 Elkridge, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician morten /Medical Examiner RONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, COHOUSM 1 X Yes 3 ☐ Probably 4 ☐ Unknown should t Be Completed 2 🗆 No CHROPAL UBSTRUCTIVE PULMONARY DISERIE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 🎢 No page PERIMONAL VASCULAR MISERIE After this certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attanding 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 Homicide after within 24 hours a To the Funeral C tha Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 02/09/2004 Ug low my 033231 10x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) " PASAVENA YAN ZIIZZ JAN KSEPINN MA Ű 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar 1 0 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2004 **Physician** Milton Williams February 11:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day Year, 1920 **Funeral** Days 1 X M 2 □ F 218 03 9979 83 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other treumatic event, the Medical Examiner must be rigitled at 1 Yes 2 X No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 - 7th Avenue 21225 U.S. or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Polices? 1 Mayes 2 □ No If Yes, Give T Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: þ Specify: White WW II 3 XWidowed 4 □ Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Sun Paper Stero Typist 10th es 1 and 2 should be filed w of Heelth and Mental Hygiel I Item 27 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton J. Williams, Sr. Annie Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Rafferty / Daughter 208 - 7th Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Importent: If iter
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Mem. Gardens 2/11/2004 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses PDCe 4001 Ritchie Highway Baltimore, Maryland 21225 ramerouse Approximate Interval Between Onset and Death Part1. Enter the disease, or comples shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Lens Sequentially list conditions, Examiner in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 1 NO 1 ☐ Yes 24-NO 1 Yes To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 an 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 1 0 2004 Registrar

04-063	32		For Unpend Item #23: Registrar	State of Mar 2,27,,28a-f po								03766
			Registrar  1. Decedent's Name (First, Middle, Las.			Centificat	e of Dea	aın	2. Date of De			3. Time of Death
	Physicia		LATASHA NICOLE AN						Month JANUAR	Day Y	ear	
T	/Medic Examin	_	4a. Facility Name (If not institution, give			4b. City	, Town, or Loca	ation of Death	UANUAR	4c. County of		0956_A
200	LAMITH		PRINCE GEORGES HOS		ER	CHEV	ÆRLY			PRINCE	GEO	RGES
19	Funeral		5. Social Security Number 6. Se	7. Age (	In yrs. last	Months		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da			ce (State or Foreign
W	Director			JM ZAF		Yrs. 4	26		AUG. 27	, 2003 V		NGTON, DC
3	and and		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, To	own or Location					10d	. Inside City Limits
	Maryl f ehc	ō	DC			WASHIN	CTON					XX Yes 2 No
	r 28a	Director	10e. Street and Number				p Code			10g. Citizen of Who	at Country	n
	death with the Maryland ims 23s or 28s-f show rimus to notified at		3224 E ST. SE #4				200	019		UNITED S	STATE	S
	ams arms	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece If Yes, spe	dent of Hispan	nic Origin? (Spe exican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Black,	American White, etc	
36	hours after tural', or Ita	by Fu	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes ♀∏ No If Yes, Give ✓		1 ☐ Yes	XX No Sp	ecify:		Specify: I	3LACK	
21215-0036	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiens. Is marked other than "natural", or Itams 23e or 28e-1 show aumatic event, Ita Multical Exam and must be notified at		15. Decedent's Ed	Year or Dates:	16	6a. Decedent's Usu	al Occupation			16b. Kind of Busin	ness/indu	strv
15	n nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		(Give kind of will life. DO NOT u	ork done during use retired)	g most of worki	ing			
21,	d within giene. er then "	E O	0			N/A						
pu	be filed tal Hygid d other	Be (	17. Father's Name (First, Middle, Last)				18.	Mother's Name	e (First, Middle	, Maiden Sumame)		
yla	should I nd Men marke umatic	은	RICO GLADNEY					KESHA .				
Maryland	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7							er, City or Town, St		ode)
	1 and 2 Health Iem 27 other tra		LAKESHA ANDERSON  20a. Method of Disposition	/ MOTHER	20b, Place	$3224 \pm ST$ of Disposition (Na	me of		SHINGTC Date	ON, DC 200 20c. Location - Cit		n, State
Baltimore,	permit. Pages 1 and Department of Healinportent: If Item 2 any Injury or other 2006.		12 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Conation 5 ☐ Other (Specify	Removal from State		etery, crematory or		0.2 EE	n 200/	CILTUI AND		
量	artme artme orten Injur		21. Signature of Eyneral Service Aicen		WASHI	INGTON NA 22. Name a	nd Address of	Facility		SUITLANI		
ä	permit. Departi		M-1. // a	. 4 / 1 1 / /		MARSHA 4308 S	LL'S FU UITLANI	JNERAL : D ROAD	HOME OF SULT	MARYLANI LAND, MD	),INC 2074	6
	554 3d		23a. Panti./Enter the disease, or composition, or heart failure. List only	olications that caused the	e death. D						A	pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition			NED DEATH :					C	Inset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	ce of):						
	LAdillilei	-	Sequentially list conditions,	b. Due to (or as a c	onseauen	an of\-					_	
	led nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a t	onsequent	ce or).						
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (or as a c	onsequenc	ce of):					_	
8760,	ysician ysician e buria	call	(	d								
# Box 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Medi	IS SEAMLE.									
go "	uth ce ttendii	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2	Fetal dea	ath 3 ☐Ectopic p				23d. Date of Month		ay Year
· • • • • • • • • • • • • • • • • • • •	the at	/sici	1 Yes 2 No	4 Pregnant at tir 9 Unknown	ne of death	n 5 ☐ Other (s	pecify)		-	W.G.		2)
Ma.	that the		Part II. Other significant conditions of	ontributing to death but	not resulting	a in the underlying	cause given in	Part I.	23e. Did 1	lobacco use contribu	ute to the	cause of death?
ds,	sign d be	d by					•		1 🗆	Yes 2 □ No 3	☐ Probat	ly 4 🕅 Unknown
` 100	w req	Completed							24a. Was	an 24b. We	re autops	y findings available
Re	icien: The lav certificate has rector, page 2	duo							auto perfo	ormed? dea	or to comp th? Yes 2i	pletion of cause of
tal	an: Titlica	BeC	25. Was case referred to medical				26.	Place of Death			103 21	
>	nysici nis ce I direc	ToE	examiner? 1 □ Yes 2 □ No	Hospital: 1 Inpatient	2 🗆 ER/	Outpatient 3X D	OA Other: 4	☐ Nursing Ho	me 5 Resi	dence 6 Other	(Specify)	
0 [	ng Pt fter th		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury FOUND 1	ear) En		28c. Injury at Work?		28d. Describe	how injury occurred		
sio	tendi death. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	1/22/04	8:	50 A <sup>M</sup>	1 ☐ Yes		UNKNO		or Cum I I	Pauto Alumbor
Division of Vital Record	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	Certification:	4 Homicide determined	28e. Place of Injury building, etc. FOUND IN DW	(Specify)		ry, office		City or To	Street and Number wn, State) 329 Al	VACOST	TA RD., APT.
	spitel ours neral filled		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of			d at the time, da			INGTON, D.C.		ed.
	e Ho	Medical	(Check only 2 Medical Exam	niner: On the basis of e and manner state	xamination	and/or investigation	n, in my opinior	n, death occurr	ed at the time,	date and place, and	due to th	ne cause(s)
	To the within To the Comp	Ň	29b. Signature and title of certifier			29	c. License nur			29d. Date signed (	Month, Da	ay, Year)
			> hy hi	ini			OC	ME		JANUARY	23,	2004
CR			30. Name and address of person who call the call		th (Item 23							
	01	10	31. Date filed (Month, Day, Year)	32. Registrar	s Signature		Stree	t, Balt	imore,	Maryland	_2120	01
	Sta Registi		JAN 3 0 2004		-	backs						

State of Maryland / Department of Health and Mental Hygiene 03767 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edna Wade Allen 14,2004 January 11:26pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hosp Takoma Park Prince Georges If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 💢 F Vrs Director 578-54-7676 Dec 1,1936 Halifax, CO, NC 67 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b Counts 10c. City. Town or Location ral', or items 23a or 28a-f show Examinar must be notified at Yes 2□No Director Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2425 Alabama Ave 20020 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 "natural', or 1 ☐ Yes 2/OXNo Specify: þ Black 3 Widowed 4 □ Divorced ar than "nature the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Switchboard Operator Private 7 is marked other traumatic event, i Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelih and Mental Hy importent: If item 27 is marked oth any joilury or other traumatic avent 2008. Be John Richard Edmonds 2 Geneva Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry S.Allen Sr. /Son 907 Michele Ct., Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park □Donation 5 □ Other (Specify) 1-23-04 Landover, MD ore of Funeral Service Licensee 21. Sig 22. Name and Address of Facility Alexander S. Pope Funeral Home 2617 Penn. Ave S.E. Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 **N**o 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funerel Direct 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29c. License number 29b. Signature and 52 l l 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHATRATHI 8100 Goodbuck Rd. LANHAM State Registrar

• Uf	To the Hospitel within 24 hours a To the Funeral completely filled	Modical
*	Sta Regista	ate rai

			1 - For State Registrar	State of Marylan		artment rtificate			nd Me	ntal Hy	giene		04	03768	3
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARGIE FREEMAN A						2	Date of De Month JAN		у	Yeer ) () (4	3. Time of Death 7:07P M	
<i>)</i>	Examin		4a. Fecility Name (If not institution, give s Civista Medica			]	LaP1				40	. County	of Death Char		
	Funeral Director		5. Social Security Number 6. Security Number 578 54 0464	7. Age (In yrs. 64	.,	If Under Months	1 Year Days	Hours	Min.	Date of Bi (Month, Di EPT . (	rth ay, Yeer, 06,	1939	9. Birthp Cour NOR'I	place (State or Foreign htty) TH CAROLIN	
	death with the Maryland ms 23a or 28a-f show crount be notified at	Director	10a. State 10b. County  MARYLAND CHARLES  10e. Street and Number	IND	y, Town or Lo	AD 10f. Zip						tizen of W	/hat Cour	,	
020	or Ite	d by Funerai	25 RIVERSIDE RUN D  11. Marital Status  1 Never Married 2 Married  XX Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Tyes XX No If Yes, Give Year or Dates:		206 Was Deceded If Yes, spec 1 ☐ Yes 2	ent of His ify Cubar	spanic Origi , Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or Nican, etc.)		Black		an Indian, etc.	_
9500-6171	within 72 hours ene. then "neturel' he Medical Ex	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	dent's Usua kind of work DO NOT us	k done di e retired)	tion u <i>ring</i> most (	of working			(ind of Bu	siness/Ind	dustry	
yland z	be file stal Hyg od othe event,	To Be Co	12TH 17. Father's Name (First, Middle, Last) JAMES FREEMAN		SEC	CRETAR		18. Mother		First, Middle		ASA Sumam	е)		
Mar	1 and 2 should Health and Mer em 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty ROBIN ANDERSON / D	AUGHTER	25 RI	ng Address VERSI	DE R		IVE	INDI				Code) 20640	
Baltimore,	ot Hor		20a. Method of Disposition  XXBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	lace of Dispo emetery, crea MONY M	matory or of IEMORI	her place AL_P	K. J		23, 04	L	ARGO,	MAR	own, Stete	
Balt	permit. Pag Department Important: I eny injury o		21. Signature   Funeral/Service/Incons	avstll	MA 43	2. Name and RSHAL 308 SU	L Address L S ITLA	of Facility FUNER ND RO	AL HO	OME OF	MAI LANI	RYLAN	D,IN	46	
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, of heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deather cause on each line.  a. Review Due to (or as a consequence)	cel	1				wil		etas	lair	Approximate Interval Between Onset and Death	_
760,	ate be executed hysician and hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq											
P.O. Box 68	ath certific titending p or use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fele 4 Pregnant at time of d 9 Unknown	Ideath 30	⊒Ectopic pre ⊒ Other (spe						23d. Date Mor	e of delive	ary Day Year	_
	juires that the de n signed by the a lid be detached i	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	anderlying ca	ause give	n in Part I.				16		he cause of death?	,
Records,	The law requir ate has been si page 2 should I	Completed								24a. Wa: auto perf 1 Yes	opsy formed?	P	Vere auto prior to co leath?	psy findings available mpletion of cause of	,
Zita Zita	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:			Othe	r		Check only					_
Division of Vital	Attending Physician: The lay rideath. sctor: After this certificate has by the funeral director, page 2	tion: To	27. Manner of Death  1 Natural 5 Pending	1 ✓ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work	4 🔲 Nur	28	s 5 ☐ Res				ý)	_
Divisi	in Signature	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st by)					If. Location City or To			er or Rura	al Route Number,	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, dea ition and/or in	th occurred anvestigation,	at the tim in my op	e, date and inion, death	d place, an h occurred	d due to the d at the time	e cause(: , date ar	s) and ma nd place, a	nner as s and due to	tated. o the cause(s)	
	To the within 3 To the comple	Σ	29b. Signature and title of certified				License		^		29d. Da	ate signed	(Month,	Day, Year)	
,	(3)		30. Name and address of person who c			, Print)		5694			ì	17	104		
	Sta	ate	Kam'akshi Baig 1 31. Date filed (Month, Day, Year)				e 10	2 La	Plat	a, M	D 20	0646			_
3	Regist		JAN 2 1 2004	32. Registrar's Signa	Browl	el.									

			For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artmen rtificat	t of He e of E	ealth a Death	and Me	ental Hy	giene Reg. No.	200	4 03	769
	100		Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Yee	3. Time o	of Death
	Physicia /Medic	_	Mary Alic	e Aus	ten						Januar				ΑM
,	Examin		4a. Facility Name (If not institution				1		Location o	of Death			County of De		
			Montgomery C			to a s. to hade also al.	i	Iney	If Under 2	24 Hrs	9. Date of Bir		Montgo		as Fasaian
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. 88	Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, De May 25	n <i>y, Year)</i> 101	5 No.	irthplece (State Country) w Jerse	
ď.	Director	-	088-07-8930 Usuel Residence of Decedent		00					1	May 23	, 171	JINE	w Jerse	у 
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside 0	
	a-f s	cto	Maryland Montg	gomery	No	orth Po	otoma	С							s 2 <b>∑</b> No
	or 28	Directo	10e. Street and Number				10f. Zip						en of What		
	death with the Maryland ms 23a or 28a-f show		14440 Rich Br			C 12		0878	annin Orio	min2 (Cno	ofty Voe or No		ed St	nerican Indian,	
	d within 72 hours after death with the Marylan riban . I han 'natural', or liams 23a or 28a-1 show the Madical Examinar must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F	cedent Ever in U. orces? 2 (2) No				n, Mexican	n, Puerto F	cify Yes or No Rican, etc.)	'	Black, WI		
2	urs af	by	3 X Widowed 4 □ Divorced	If Yes, G Year or I	ive		1 🗆 Yes	2 🖾 No	Specify:				Specify:	White	
2-UU30	72 hours after natural", or ite	Completed	15. Decedent (Specify only highes	's Education	1)	16a. Dece	kind of wo	rk done di	urina most	t of workin	na	16b. Kin	d of Busines	ss/Industry	
7	within 7 iene. than the	npie	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT u	se retired)			3				
7	e filed will Hygien other th	S	A TO PROVIDE A SALE OF THE PARTY OF THE PART		2	Mothe	er		10 Matha	da Alama	(First, Middle,	Ho			
and	be fill H all H all H	Be	17. Father's Name (First, Middle,	Last)							cDonnel		sumame)		
2	hould d Men marke matic	မို	Robert Way  19a. Informant's Name/Relationsi	hip (Type Print)		19b. Mailir	na Address	(Street a			Route Numb		Town, State	. Zip Code)	
2	and 2 s ealth an n 27 is ner traus		Robert T. Aus		ı	14440	_							D 20878	
ā,	一主英英。		20a. Method of Disposition			lace of Dispo emetery, crei	sition (Name	me of other place	,		ate	20c. Loc	ation - City	or Town, Stete	
Ē	Pages nent of ant: If it		1 🕅 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		n State	e of H	-			Jan. 2004	21,	Silv	er Spi	ring, MI	)
aitimor	porter porter y inju		21. Signature of Fundral Service	Licensee		22	2. Name ar	nd Address	s of Facilit	y DeVo	ol Fune	era1	Home		
מ	88 58	1 12	fort (	·M		1	0 E.	Deer	Park	Dr.	Gaitl	iersb	urg, l		
			23a. Part 1 Enter the disease, or shock or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	ter the mod	te of dying	, such as	cardiac or	respiratory a	rrest,		Approxima Interval Be Onset and	etween
>	Physician		Immediate Cause (Final disease or condition resulting in death)	a	13	chemi	cl	oow	el					1 dx	
	/Medical Examiner		resuling in dealin)	Due to	o (or as a conseq										J
		-	Sequentially list conditions, if any, leading to immediate	b. — Juak	Or se a coneaq	iato	eres								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	A.	thro s	مره ان	-oti	W	140 C	ساس	27.6	ease			
ລົ	exection and and rial-tra		resulting in death) Last		o (or as a conseq	uence of):									
9/8	certificate be executed rding physician and use as the burial-transit	Icai		d	Hyper	tens	ion	<u> </u>							
Õ	leath certifica attending ph I for use as th		IF FEMALE:					-							-
ROX	death ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Feta	I death 3	Ectopic p					2	3d. Date of o Month	delivery Day	Year
9	0 0 0	ysic	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9□ Unk	gnant at time of d nown	eath 5L	Other (s	оеспу)							
ב	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	inderlying (	ause give	n in Part I.	,	23e. Did 1	obacco us	se contribute	to the cause of	death?
g	w requires that been signed t should be deta	d by									1 🗆	Yes 2	]No 3□	Probably 4	Unknown
ecords,	s bee	jete									24a. Was		24b. Were	autopsy findings o completion of	s available
r	sician: The law certificate has t lirector, page 2 s	Completed									auto perfo	rmed?	death	es 2 No	cause of
Vital	sian: artifica ctor. p	Be C	25. Was case referred to medica examiner?						26. Place	of Death	(Check only				
	Physic this ce al dire	70	1 ☐ Yes 2 📉 No			ER/Outpatie			4 🗆 190		ne 5 ☐ Resi			pecify)	
n O	ding P. h. After t funera	lon:	27. Manner of Death 1 X Natural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time o Injury		28c. Injury Work			8d. Describe	how injury	occurred		
Division of		cat	2 Accident investi 3 Suicide 6 Could	not be and Die	ce of Injury - At h	ome farm st	M factor		/es 2 🗆		18f. Location /	Street and	d Number or	Rural Route Nu	mber.
≥	i or Attan after deatl Director:	Certification;	4  Homicide determ	buil buil	ding, etc. (Specia	y)	1001, 120101	y, omoc			City or To	wn, State)			
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b.		29a. Certifier 1X Certifyir	ng Physician: To th	ne best of my kno	wiedge, deat	th occurred	at the tim	e, date an	nd place, a	nd due to the	cause(s)	and manner	as stated.	
	he Ho in 24 he Fu pletel	edical	(Check only 2 Madical one)	Examiner: On the and ma	nner stated.	ition and/or in	vestigation	, in my op	inion, dea	ith occurre	d at the time,				(S)
	With To t	Σ	29b. Signature and title of certifie	11-1-	20		29	c. License						onth, Dey, Year)	
7	J		Joanes	1	~>			03	9190	2		Janu	ary 1	2004	
	1		30. Name and address of person		•	n 23a) (Туре, 3418		WOOA	Cour	·r #1	11 01-	iev.	Marv1:	and 2083	32
1940	St.	ate.	Joseph Garre 31. Date filed (Month, Day, Year)		Registrar's Signa		-			11 1		.c,	, 10		
	Regist		JAN 2 0		Beneva	B	140	aks							

		1 - For State Registrar	State of Marylan	-	artment of F rtificate of				Reg. No.	200	. 00	770
Physic	ian	Decedent's Name (First, Middle, Las						<ol><li>Date of De Month</li></ol>	Day	Yeer		
/Med		WILLIAM	ANOLIK		4b. City. Town, o		_	ANUARY		2004 ounty of De	4:35	A M
Exami	ner	4a. Fecility Name (If not institution, give	street and number)			or Location of	Death			TGOME		
Francis		SUBURBAN HOSPITAL 5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday,	BETHESDA If Under 1 Year			8. Date of Bir	th	9. B	irthplece (State	or Foreign
Funeral Director			WM 2□ F	7 Yrs.	Months Days	Hours	Min.	(Month, Da			V YORK	
p.		Usual Residence of Decedent								1	Table 1 and 1 and	22.11.22
ith the Marylan or 28a-f show	_	10a. State 10b. County		y, Town or L	ocation						10d. Inside C	s 2 No
Ba-f	Director	MARYLAND MONTGOME	RY NORT	H POTO					10- Citi-	a of Milan		
with the	DIL	10e. Street and Number			10f. Zip Code	•				on of What (	Jountry ?	
7.72 hours after death with the Maryland "netural", or items 23s or 28s-f show adical Examinst must be notified at	Funeral	14017 FOREST RIDG	E DRIVE  12. Was Decedent Ever in U	S 13	Was Decedent of H		nin? (Spec		U.S.A		nerican Indian,	
iter d	Ē	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No		If Yes, specify Cub	an, Mexican,	, Puerto F	Rican, etc.)		Black, Wh	nite, etc.	
urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1942	2-45	1 ☐ Yes 2 🗶 No	Specify:			5	specify: W	HITE	
72 hours after netural', or ite	Completed	15. Decedent's Ed			edent's Usual Occup kind of work done		t of workin	na .	16b. Kind	d of Busines	s/Industry	
within ene. then	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		•				
filed w Hygier other th			5+	PHYS	CIAN	40 14-15-	d. No	(Fire a distribute	MEDI			
d be fit antal H sed oth	Be	17. Father's Name (First, Middle, Last)					r's Name	(First, Middle				
2 should be and Mental is marked or	ဥ	HARRY  19a. Informant's Name/Relationship (	ANOLIK	10h Mail	ing Address (Street	LENA	or Oural	I Cauda Alumb	KEIT		Tin Code)	
s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental Hygiene.				1					_			0
1 and Health Health		STUART H. ANOLIK/ 20a. Method of Disposition	20b. F	Place of Disp	FOREST osition (Name of			NUKIH			or Town, State	0
8 = = 5 V		1 XBurial 2 Cremation 3	Hemoval from State		matory or other pla		11/12	/2004				DV
rmit. Parpartmen portant: y injury		<ul><li>4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer</li></ul>			N CEMETE:			/2004			NEW YO	W
Depariment of the part of the		19/	m	E1 10	2. Name and Addre DWARD SAG 091 ROCKV	EL FUN	NERAL PIKE,	ROCKV	TION,	INC. MD 2	0852	
Physician		23a. Part1. Enter the disease, or com shock, be heart failure. List only Immediate Cause (Final disease or condition	plications that caused the deal one cause on each line.  PULMONARY EI		iter the mode of dyi	ng, such as	cardiac or	r respiratory a	rrest,		Approxima Interval Be Onset and	etween d Death
/Medical		resulting in death)	Due to (or as a consec	<del></del>								
Examiner	ł.	Sequentially list conditions	b ACUTE RENAL		RE						48 HOU	RS
be sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec								/ 0 TIOTI	m c
ate be executed hysicien and the burial-transit	хап	that initiated events resulting in death) Last	c. ACUTE HEPATI								48 HOU	ΚĐ
ate be e hysicien the buria	0											
certificate ding phys	edic		_ d									
leath certifica attending ph	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn.						23	3d. Date of c	lelivery	
death cer	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic pregnand □ Other (specify) _	:у				Month	Day	Year
that the ded by the	hysician/M	9 Unknown	9□ Unknown									
requires that the detention of the detection of the detec	by P	Part II. Other significant conditions of	contributing to death but not res	sulting in the	underlying cause gr	ven in Part I.		23e. Did	obacco us	e contribute	to the cause of	death?
law requires t as leen signe 2 should be					···			1 🗆	Yes 2X	No 3□	Probably 4	]Unknown
law re as ee	ompleted							24a. Was		24b. Were	autopsy findings o completion of	s available
0 4 9	E							auto perfo	ormed?	death	es 2 No	Cause of
sicien: The certificate	BeC	25. Was case referred to medical				26. Place	of Death	(Check only	<del></del>			
09	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 TInpatient 2	] ER/Outpatie	ent 3 DOA	her: 4□ Nu	ırsing Hon	ne 5□Res	dence 6	□Other (Sp	pecify)	
		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	ry at	2	28d. Describe	how injury	occurred		
Attending of death.	cati	2 Accident investigatio			M 1	]Yes 2 □!	-					
5 # # E	Certification:	3 Suicide 6 Could not be determined			treet, factory, office		2	28f. Location ( City or To		Number or	Rural Route Nui	mber,
Hospite 4 hours Funerel	edicai C	29a. Certifier 1 X Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my kniner: On the basis of examinated and manner stated.	owledge, dea ation and/or i	ith occurred at the t nvestigation, in my	ime, date an opinion, dea	nd place, a	and due to the ed at the time,	cause(s) a date and p	and manner place, and d	as stated. ue to the cause	(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number			29d. Date	signed (Mo	nth, Day, Year)	
1-3	1	1 > 0 1	Millman		D0046	734		1	IANIIAI	RY 12.	2004	
V		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type		.,,,,						
		IRENE FELDMAN, M.	D., 5225 POOK	S HILL	ROAD, SI	ITE 1	-A, I	BETHESI	A, M	2081	4	
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	, ,	//						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:50 P.M 2004 January Donald L. Anderson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery Layhill Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Days Hours 1**∑**M 2□ F April 2, Pennsylvania 71 Director 368-32-8308 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "natural", or items 23s or 28s-f show the Medical Example, must be notified at 11 Yes 2 □ No Director Washington D.C. None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 712 A 3rd Street S.W. 20024 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Itel ury or other traumatic event, the Medical Exerts and 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1953-55 Specify: Specify: Black Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Community Efementary/Secondary (0-12) College (1-4or 5+) Dev. Organization 5+ Lawyer 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Russell Lloyd Anderson, Sr. Celeste Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4022 Wexford Drive Kensington, Maryland 20895 19a. Informant's Name/Relationship (Type, Print) Dolores L. Farr / Sister permit. Pages 1 and Depertment of Health Important: if Item 27 any Injury or other troone. Jan. 24, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Botetourt, Virginia 4 Donation 5 Other (Specify) Daniel's Mountain Cem. 2004 22. Name and Address of Facility
DeVol Funeral Home Fungral Service Licens D.C. 20007 2222 Wisconsin Ave. N.W. Washington, Ph.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 Months Physician Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 XYes 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 ☐ Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 January 20, 2004 15185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving Street, N.W. Washington, D.C. 20010 M.D. John E. McKnight, 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2 1 2004

JAN

rough

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16, **JOHN EDWARD ADAMS** JAN. 2004 1:03 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RANDOLPH HILLS NURSING HOME WHEATON MONTGOMERY If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 215-38-3067 63 JULY 4, 1940 DELAWARE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r 28e-f show Director 1 XYes 2 No MD. MONTGOMERY WHEATON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ the Medical Examiner must be or Items 23a 4011 RANDOLPH RD. 20912 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces :

1 X Yes 2 No
If Yes, Give
Year or Dates: VIETNAM filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ⋧ Specify: 3 ☐ Widowed 4 K Divorced "natural" WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 CAB DRIVER TRANSPORTATION permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumating and injury or other traumating and the an 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EDWARD** THOMPSON **ADAMS** MABEL ETHEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANNE HALTIWANGER/SISTER 6911 CARLETON TERR., COLLEGE PARK, MD. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \*4 □Donation 5 □Other (Specify) CHAMBERS CREMATORY 1-21-2004 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A - Chane M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTICEMIA week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) o Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMONIA. DEHYDRATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 Yes 2 No Division of Vital 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oka D08944 2 JAN. 20, 2004 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) MARTIN SHARGEL, M.D. 3720 FARRAGUT AVE., KENSINGTON, MD. 20895 31. Date filed (Month, Day, Year) JAN 22 2004 32. Pegistrar's Signature State Registrar

		1 - For Stete Registrar	State of Maryland	/ Departmer		_		2004	03774
Physic /Med	ical	1. Decedent's Name (First, Middle, Last)  DAUID AB LAHAM  4a. Facility Name (If not institution, give s		dh Cib	Town, or Location of	JAN	UARY	y Year 13 ; 2004 . County of Death	3. Time of Death
Funera Director		6. Sex 010-05-0577	UN GUA MOITATH	2SING SA st birthday) If Unde		24 Hrs. 8. Date	1	10 NT GO.	DIERY place (State or Foreign intry) sechusetts
th the Maryland or 28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgome           10e. Street and Number		Town or Location  Lver Sprin  101. Zi	g o Code		10g. Cit	izen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exertinative multipled at	Funeral	15100 Interlachen  11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced		0906 dent of Hispanic Orig cify Cuban, Mexican 2닻No Specify:	gin? (Specify Yes i, Puerto Rican, et		14. Race - Ameri Black, White,	can Indian,	
Maryland 21215-0036 at 2 should be filed within 72 hours aff than and Mental by giene. By Is marked other than "natural, or traumatic event, the Medical Exercitival and the standard and the sta	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usu (Give kind of w life. DO NOT	ork done during most ise retired)	t of working	16b. K	ind of Business/Ir	
ryland though though the file of Mental Hyg marked other matic event,	To Be C	17. Father's Name (First, Middle, Last)  Joseph Abel  19a. Informant's Name/Relationship (Typ.	ne. Print)	19b. Mailing Addres	Ţ.	or's Name (First, M da ar or Bural Boute I	Yaft	i	n Code)
Baltimore, Ma Demit. Pages 1 and 2 s Department of Health an Mportant: if item 27 Is.	1 8	June Abel, Wife  20a. Method of Disposition  1 ⊠ Burial /2 □ Cremation 3 □ Re  '4 □ Donation /5 □ Other (Specify)	20b. Pla		erlachen l	Dr., #81	7 Silve		g, MD 20906 own, State
Baltii permit. F Departm importer any inju		21. Signa ure of Fineral Service Lio-ns	Jusi.	22. Name a Edward 1091 R	nd Address of Facilit Sagel Fun ockville	y neral Di Pike, Ro	rection	ı, Inc.	0852
Pnysiciar /Medica Examine		23a. ParM. Enter the disease, or complie shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ASPIRATION  Due to (or as a conseque	UBU9 C		cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death D.A. Y.S.
7 <b>60,</b> te be executed ysician and be burial-transit	Ical Examiner	Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	į	VEARS					
. Box (death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	feath 3 □Ectopic p				23d. Date of deliv Month	ery Day Year
Records, P.O The law requires that the ate has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying	cause given in Part I.	23e.	Did tobacco		he cause of death?
	e Completed	25. Was case referred to medical			26 Place		Was an autopsy performed? Yes 2€ No	prior to co death?	opsy findings available impletion of cause of
T ge al	ertification; To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1   Inpatient   2   El   28a. Date of Injury (Month, Day Year)   2		0.1	rsing Home 5 28d. Des		6	y)
Division Hospital or Attending 24 hours after death. Be Funeral Director: After	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	nd Number or Rura ))					
To th withir To th	Medical	(Check only 2 Medicel Exemin	icien: To the best of my knowl ler: On the basis of examinatio and manner stated.	on and/or investigation	i, in my opinion, deat	th occurred at the	time, date and	d place, and due to	o the cause(s)
8		30. Name and address of person who co	mpleted cause of death (Item 2  MAN M.D. 181  32. Registrar's Signatu	/SICIAN 23a) (Type, Print) 100 SLADS	ScHOOL R	POAD SAM	JANG	12N4, U	20860 ARYLAND
S Regis	ate trar	31. Date filed (Month, Day, Year) JAN 2 0 20	32. Registrar's Signatu	re & A	parks				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Alice Abdow Jan.14,2004 6:30pm /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Bethesda Bethesda Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1□ M 2XF 027-09-2872 92 Vrs Director 11/10/1911 Worcester, MA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury go other traumatic event, the Medical Examinat must be notified at any injury go. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Montgomery Bethesda 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 Democracy Blvd. 2 - 817Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1₺ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Self Employed Photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Francis Abdow Besma Abdow ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Abdow/Nephew 9425 Spruce Tree Circle Bethesda, Md 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 1/20/04 Silver Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
PHILIP D.RINALDI FUNERAL SERVICE, P.A.
9241 Columbia BLvd Silver Spring, Md20910 21. Signature of Juneral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Urosepsis Examiner Due to (or as a consequence of) by Physiclan/Medical Examiner Pre-renal azotemia or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, any Lating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Alzheimer's disease Due to (or as a consequence of): Atrial fibrillation Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No hypertension within 24 hours after death.

To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed diabetes mellitus 1 ☐ Yes 2 ANO 1 ∏ Yes 2 ∏ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 □KNo Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 Jan.14,2004 d address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd.Bethesda, Md 20817 Kirti Vohra MD

DHMH 16 Ray 6/95

State Registrar 31. Date filed (Month, Day, Year) JAN 21 2004

32. Registrar's Signature

Aa. Fecility Name (If not institution, give street and number)   Ab. City, Town, or Location of Death   Ac. County of Death			1 - For State Registrar	State of Maryland	•	artment of H			giene 2001	+ 03776
Second Second Control   1	/Med	ical	Lewis Dale Ba	rton		4b. City, Town, or	Location of Dea	Januar	y 20 2004	12:45A M
106. Date   106. County   106. Date   10	Funeral		5. Social Security Number 6. Social Security Number 6. Social Security Number 1	-TT		If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt Month, pa June 19	h a Ri	rthplace (State or Foreign
The stands Name (Fried, Mickele, Last)  Norris D. Barton  Dovie M. Richardson  Dovie M. Richa	r death with the Maryland ems 23a or 28a-f ehow er mat be notified at	ctor	MD 10b. County Prince G			2				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
To provide the provided by the		uneral Dire	3911 York Lane	Armed Forces?	13.	20			USA	erican Indian,
The father's Name (First, Meddle, Last)   The Mortris D. Barton   Dovie M. Richardson Sumanney   The Mortris D. Barton   Dovie M. Richardson Sumanney   Dovie M. Dovie M. Richardson Sumanney   Dovie M. D	n 72 hours aft	by	3 ∰Widowed 4 □Divorced  15. Decedent's Ed	dent's Usual Occupa	ation	orking				
20. Lakemost of Dispassion   Date   D	be filed tal Hygi	Be	17. Father's Name (First, Middle, Last)		ector 18. Mother's Na	ame (First, Middle,	Maiden Sumame)	ernment		
Physician (Modical Examinor  Physician (Modical Examinor)  Physici	3, Mar y is and 2 should lealth and Mei m 27 is mark her traumatio	To	19a. Informant's Name/Relationship (	Гурв, Print) Pers. Rep.	14300	) Gallant	nd Number or F Fox Lan	Rural Route Numbe	or, City or Town, State,	, MD.20715
Physician (Medical Examiner)  Physic	Smit. Pages separtment of hoportant: If ite hyportant: If ite hypiny or of hice.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	Lake	emont 2	Mem. Gard 2. Name and Addres	lens 1-2	2-2004 eall Fun	Davidsonvi eral Home	ille, MD.
Due to (or as a consequence of):    State   St	Physician /Medica		shock, or heart failure. List only Immediete Cause (Final disease or condition resulting in death)	one cause on each line.  Pneumonia	Do not en		·	<del>-</del>		Approximate Interval Between Onset and Death
9 Unknown 9 Unkn	2 × 5	ical	Cause (Disease or injury that initiated events	Due to (or as a consequence.		S &				
Chronis Obstructive Pulmonary Disease    Chronis Obstructive Pulmonary Disease   24a. Was an autopsy findings availab prior to completion of cause of death course of death course of the course of death cour	. 0 0 0	ysician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	dent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy 112 months? 4 Pregnant at time of death 5 Other (specify)						
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1   Impatient   2   ER/Outpatient   3   DOA    28. Date of Injury   28d. Describe how injury occurred   28d.			Coronary Artery	Disease			en in Part I.			
29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29c. License nu	(al Meconn. The law reficate has be or, page 2 sh			tive Pulmonary	Disea	ase	OS Blass of D	autop perfo 1 ☐ Yes	rmed? death? 2 No 1 □ Ye	
29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29c. License nu	IOD Of VII nding Physicia tth. :: After this cert e funeral directs	ုင	examiner? 1 Yes 25 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injun Work	<sup>9f:</sup> 4 ☐ Nursing ⁄ at ⟨?	Home 5 Resid	dence 6 Other (Sp	ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kelvin Hao, M.D. 14999 Health Center Dr. Suite 201 Bowie, MD. 20716  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	pitel or Atter ours after dea neral Director		3 Suicide 6 Could not be determined	building, etc. (Specify)	)		ne, date and nia	City or To	vn, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kelvin Hao, M.D. 14999 Health Center Dr. Suite 201 Bowie, MD. 20716  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To the Hos within 24 h To the Fun completely	Medica	(Check only 2 Medical Examone)	niner: On the basis of examinati and manner stated.	ion and/or ii	29c. License	pinion, death oc number	curred at the time,	date and place, and du 29d. Date signed (Mon	ne to the cause(s)
	2(3)1	la l	Kelvin Hao, M. 31 Date filed (Month, Day, Year)	D. 14999 Healt	th Cer	nter Dr.	Suite 2		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item#1, per Dr, 4528, 2711/2004, Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARGARET P. BUZY **Physician** MARGAROT BUTY 2004 1030AM 162 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1□M 2፟AF 058-26-7803 72 Director Aug. 23, 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show mortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Modical Examiner must be notified at once. Funeral Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11709 Stonewood Lane 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Massage Therapist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Healy Margaret Tracy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Buzy/ Husband 11709 Stonewood Lane, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 21 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State Metropolitan Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, Vircinia 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MUGIPLE myElon A 4years **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical the attending for use as use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached o 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, DUTTE RENM FAILUIE 1 Yes 2 No 3 Probably 4 Unknown Completed PNELM-114 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 2 No certificate Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 12 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔀 No Certification: To this ( Division of filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D29675 JAN 20 ZOOM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BeTHESDA, MD BOCCIA Karpij トワ 10470 Bocklos6 31. Date filed (Month, Day, Year) JAN 22 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State o	f Marylar		artmen rtificat					Reg. No.	2001	+ 037	778
	Dhysisi		1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	ath Day	Year	3. Time of I	Death
	Physici: /Medic		Elizabeth	Mish	3	Butler					Jan.	4,	2004	6:55A	М
	Examin		4a. Facility Name (If not institution, gr	ve street and nur	nber)		4b. City,	Town, or	r Location of	of Deeth		4c.	County of Dea	th	
			Washington Adven		-				Park				ontgome		
	Funeral			Sex 1 □ M 2 🖾 F	7. Age (In yrs. 88	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	C	thplece (Stete or ountry)	Foreign
13	Director		447-22-5614 Usuel Residence of Decedent			115.					Jan. 29	9, 19	915  Vi	rginia	
	and and		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City	y Limits
	f sho	ō	Maryland Montag	m o 1411	C + 1-	7036 Cma								1 Tyes	2 ⊠ No
	28s	Je C	Maryland   Montgo	mery	1911/	ver Spi	10f. Zip	Code				10g. Citi	zen of What C	ountry?	
	3a or		9201 Wire Aveu	ne			1	2091	0			Uni	ted Sta	ates	
	72 hours after death with the Maryland natural; or Items 23e or 28e-f ahow iteal Examinaer must be notified at	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	-	14. Rece - Am		
9	after or Ite	Ē	1 Never Married 2 Marned	Armed Fo	2 ☑ No						Hican, etc.)		Black, Whi		
93	ral',	i by	3 Widowed 4 Divorced	If Yes, Giv Year or D	ates:		1 🗋 Yeş	ZAI NO	Зр <del>а</del> спу:				Specify: V	√hite	
21215-0036	72 h 'natu	Completed	15. Decedent's 1 (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT u	al Occup nk done	ation during mos	t of worki	ng	16b. Ki	nd of Business	/Industry	
121	Athin ne. hen	mpi	Elementary/Secondary (0-12)	College (1	I-4or 5+)				d)				111 0		
2	fygie her t		17. Father's Name (First, Middle, Las	4	<del></del>	1	Librai	cian	19 Moths	orla Niama	(First, Middle			chool Sy	stem
anc	hail Hed of	Be	William Graham	Mish							ing Cle				
Ž	d Mer d Mer nark natic	ို	19a. Informant's Name/Relationship			10b Maili	na Addross	(Ctroot					r Town, State,	Zin Cadal	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f ahow amportant: if Item 27 is marked other than a natural; or Items 23a or 28a-f ahow amportant: if Item 27 is marked other than 2000 or Item 20		Graham M. Butler			2499	Rice	St.	, #12.	5, Ro	sevill	e, M	N 5511	. 1	
	1 an Heal em 2	see.	20a. Method of Disposition	(5011 )	20b. I	Place of Dispo	osition (Nar	ne of	-	D	ate	20c. Lo	cation - City or	Town, State	_
Baltimore,	ages of or o		1 Burial 2 ☐ Cremation 3		State Be	cemetery, cre the P	matory or o	ther place Leri	ån J	арцаг	y 12		nton, \		
Ħ	permit. Page Department of Important: If any injury of once.		' 4 □ Donation 5 □ Other (Spec	-	Cn	urch Co									
Ba	Depin any onc				ff A	A	app	une	ral A	nd Ci	rematio	n Se	rvices	1910	
			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral And Cremation Services 933 Gist Ave., Silver Spring, MD 20910  23a. Part 1. Enter the disease, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										Approximate		
			shock, or heart failure. List on Immediate Cause (Final	y one cause on e	a n line.									Onset and D	
	Physician /Medical		disease or condition resulting in death)	a	Ischem:		diomy	opai	thy						
	Examiner			540 (0	Coronai		ery	Dise	2266						
	.*	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	(ui as a culised		CLY	DIO	case						-
	outed Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c											
o,	be executed ician and burial-transit	EX	resulting in death) Last	Due to	(or as a consec	quence of);									
8760,	y s	icai		d							· · · · · · · · · · · · · · · · · · ·				
9	leath certifica attending ph I for use as th	Med	IF FEMALE:									1			
Вох	Ith ce Itendi	an/l	23b. Was decedent pregnant in the past 12 months?		tcome of pregn pirth 2 Fet	al death 3[	⊒Ectopic p		,			1 :	23d. Date of de Month	,	'ear
	e dea the at	sici	1 Yes 2 XNo	4☐Pregr 9☐Unkn	nant at time of o	death 5[	Other (sp	pecify)					Month	Day 1	841
P.0	d by etach	Physician/Med	Part II. Other significant conditions	contribution to d	anth but not so	autting in the c			an in Danil		22a Did t		an anatributa t	o the cause of de	nath?
	The law requires that the death Ite has been signed by the atter vage 2 should be detached for u	by	=	ignancy.		-	inderlying d	ause giv	en in Pan i	١.	1.			robably 4 XIU	
oro	w require been signal	ted									-	1663 21	7140 201	100abiy + 250	TIKITOWIT
ec	e law has b je 2 sl	Completed	Primary Unknow	n							24a. Was autoj	psy	prior to	utopsy findings a completion of ca	ivailable iuse of
H		Cor									1 Yes	med? 2  No	death? 1 ☑ Yes	s 2 No	
/ita	Attending Physician: The death.  ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospitali							(Check only o				
of.	Physic this c	10	1 Yes 2 No			ER/Outpatie			4 🗀 140				6 ☐Other (Spe	ecify)	
ň	ding F h. After funera	on:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time o		28c. Injur Wor			28d. Describe	how injur	y occurred		
Sic	uttendi death. ctor: A y the fu	cat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be -	As h	1	M		Yes 2		206 1 0 1 /	C4		David Clarks	
Division of Vital Records,	or Al	Certification:	4 Homicide determine	build	of Injury - At hing, etc. (Speci	ify)	reet, tactor	у, опісе		4	City or To			lural Route Numb	76 <i>r</i> ,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	S	29a. Certifier 1 X Certifying I	hysician: To the	a heet of my k-	Owledge do-	th occurred	at the ti-	ne data co	ad place	and due to the	names (.)	and manage	e stated	
	24 ho Fun Fun	edical	(Check only one) 2 Medical Ex	aminer: On the b	asis of examin	ation and/or in	vestigation	at the tir i, in my o	ne, date ar pinion, dea	ath occurre	and due to the ed at the time,	date and	and manner a place, and du	s stated. e to the cause(s)	i
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and man	^		29	c. Licens	e number			29d. Dat	e signed (Mon	th, Day, Year)	
			) (Mm	.1	1111)		D2	2039	1				21-04		
	10		30. Name and address of person wh	o completed com	se of death (Ite	m 23a) (Tuna	Print								
			Jeffrey A. Kelm					ad Hy	vatte	vi112	. MTN	2078	2		
	Sta	ite	31. Date tiled (Month, Day, Year)	32. F	Registrar's Sign		1	pou		<u> </u>	- 9 1111/	20/0	<u> </u>		
	Regist		JAN 23	2004	Dener	100	1 14	con	ROLL						

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 13 2004ª **Physician** 4:26 PM F. Bredice Don /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Montgomery Shady Grove Adventist Hospital Rockville KOCKVIIIC

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Oct. 2, 1918 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 85 Washington, DC 579-16-6658 Director Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show injury of other traumetic event, the Medical Examiner must be rightled at 1 ☐ Yes 2 No Maryland Directo Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Items 23a 9614 Duffer Way 20879 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury grether frammer. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Shoemaker 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Michela Pirrone Francesco Bredice 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germantown, MD 20876 20302 Brook Run Place Daniel Bredice / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 17, Columbia Gardens Arlington, Virginia 2004 21. Signature of 22. Name and Address of Facility uneral Service-Lice ODCO. DeVol Funeral Home Gaithersburg, MD 20877 10 E. Deer Park Dr. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Minutes Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4 Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death detached 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by shoutd be 2 X No Atrial Fibrillation 1 Yes 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 13, 2004 051714 30. Nam a and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd. #102 Rockville, Maryland 20850 Jatinder Singh Sekhon, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2004 12:45 A Berlinsky January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1QM 2□F 29, 1908 Director 579-16-4739 95 Washington. DC Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or iteme 23a or 28a-f show Exeminer must be notified at 1 ☐ Yes 2 ☐ No DC Washington None Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20016 United States 4101 Cathedral Avenue, NW Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "naturel", or itemportant: in item 27 is marked other then "naturel", or itemportant injury or other traumatic event, the Mudical Examina once. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 No Specify: Specify: white Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Transportation Specialist U.S. Navy Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be "Unknown" **Berlinsky** Sophie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Cathedral Avenue, NW #910 Washington, DC 20016 Jeanne M. Berlinsky, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☑ Cremation
4 ☐ Donation /5 ☐ Other (5 3 Removat from State 5 Other (Specify) Judean Memorial Garden 1/11/04 Olney, Maryland 21. Signature of Funeral Service Likensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. take 1170 Rockville Pike, Rockville, MD 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) the a ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 3 ☐ Probably 4 ☐ bnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 9 No Hospitel or Attending Physicien: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Vitin 24 hours are: .... investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5525 10 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilks. MONTROSE 10 AD RUCKULLE B 6121 MARYIMO Jary 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature parker State 1 Ryana Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			riease	State of Ma					-				
			1 State	State of Ma	iryland / i		ificate o		i wentai m		2001.	037	2 1
	.j. 198		Registrar      Decedent's Name (First, Middle, Last,			0071	meate of	Death	2. Date of D	Reg. No	0. 2 0 0 7	3. Time of Dea	U I
# C	Physici /Medio Examir	al	Walter Willia  4a. Fecility Name (If not institution, give	am	Brandt		4b. City. Town	or Location of De		-	Yeer 6, 2004 c. County of Death	5:10 8	
2000	Examir	iei	Hillhaven Nursing		C.		Ade1p			1	Prince Ge	orge's	
3	Funeral		5. Social Security Number 6. Sec		(In yrs. last bi			r If Under 24 H				place (State or For	reign
u.	Director		578-10-0116 Usuel Residence of Decedent	M 20 F	93	Yrs.			Oct. 2	6, 1		ginia	
	land ow	10a. State 10b. County 10c. City, Town or Location									1	10d. Inside City Lir	mits
	Many Perfeh	tor	Maryland Montgom	nerv	Si	llver	Spring	ž				1 □ Yes 2 🛭	No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Cour	ntry?	
	ath w 9 23e	rai	1415 Stateside				20903				USA		
	iteme	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		13. Wa	as Decedent of Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White,	etc.	
036	urs aff	by	3 ☑ Widowed 4 □ Divorced	1 🖾 Yes 2 🔲 N If Yes, Give Year or Dates:	ŬWWII	1 [	☐Yes 2. 12 N	Specify:			Specify: Whit	:e	
2-0	be filed within 72 hours after death with the Maryland tat Hygiene. Ad other than "natural", or Iteme 23a or 28e-1 ahow event, the Medical Examinational perioditied at	Completed	15. Decedent's Edu (Specify only highest grade	ication	16a	. Deceder	nt's Usual Occ	upation	orkina .	16b. K	(ind of Business/In	dustry	
21	within ene.	mpie	Elementary/Secondary (0-12)	College (1-4or 5-	+)			e during most of w	, smill g		icipal Al		
2	a filed within it Hygiene. other then		12 17. Father's Name (First, Middle, Last)		Chief Inspector  18. Mother's Name (Fir.					_	trol Boar	rd	
au	d be antai ked o	To Be		Brandt							,		
ary	should be ind Mental marked umatic ev	۲	George Gerhardt Brandt  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City o									Code)	
Σ	and 2 saith a n 27 is		Beverly A. Brandt,	/ Daughter				de Drive	, Silver	Spr	ing, MD 2	20903	
Baltimore, Maryland 21215-0036	T Ses -		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R	Removal from State	Park	of Disposit ary, crema	tion (Name of Memoria k	Jan	Date uary 20	20c. L	ocation - City or To	wn, State	
Ħ	t. Partmen		* 4 □ Donation 5 □ Other (Specify)	_					2004		kville,	Maryland	
Bal	permit. Pages I and 2 should be Department of Health and Menta Important: if Itam 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licent	90		Fra	ncis J.	Collins	Funeral	Hom	e Inc. er Spring	MD 000	0.1
			23a. Part1. Enter the disease, or compli	ications that caused	the death. Do						er Spring	Approximate	
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	Dehydrai								Onset and Death	
	/Medical		resulting in death)	Due to (or as a		of):							
	Examiner	_	Sequentially list conditions,	Dysphag:									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer Union lying Cause (Disease or injury	Due to (or as a									
<u>,</u>	te be executed ysicien and e burial-transit	xan	cause (Disease or injury that initiated events resulting in death) Last  Failure To Thrive  Due to (or as a consequence of):								-		-
760,	ite be executed lysicien and he burial-transit	cal	ι,	status ]	Post Hi	p Re	placeme	nt					
89	death certificate e attending phy id for use as the	by Physician/Medi	IF FEMALE:									0.52	
Вох	ath ce ttendii or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	2 Fetal death		ctopic pregnan	су		1 6	23d. Date of delivery  Month Day Year		
P.O.	0 0 0	ysic	1 Yes 2 No	4☐Pregnant at t 9☐Unknown	ime of death	5 🗆 C	Other (specify)				WOITH	Day	
	law requires that the de as been signed by the 2 should be detached	y Ph	Part II. Other significent conditions con	ntributing to death bu	t not resulting i	n the und	erlying cause g	iven in Part I.	23e. Did	tobacco i	use contribute to th	ie cause of death'	?
rds	quires tha in signed uld be del	g pe	Coronary Artery D	isease					10	Yes 2	Mo 3 ☐ Prob	ably 4 DUnkno	own
900	aw re as bee 2 sho	Completed	Dementia						24a. Was		24b. Were auto	psy findings availa	able
Ě	The ate ha	Com							auto perfo	ormed?	death?	npletion of cause	OI
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				The second section is	eath Check on				
of	Phys	<u>و</u>	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 Inpatien	t 2□ER/Ou	utpatient Time of	3□ DOA 28c. Inju		Home 5 ☐ Resi		6 Other (Specify	"	_
O	th. : Afte	tion	1   Natural 5 □ Pending 2 □ Accident investigation	(Month, Day		Injury	W	ork? ]Yes 2 □ No	250. 2030100	now inju	ry occarred		
Division of Vital Records,	or Attending ifter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	ry - At home, fa	arm, street	t, factory, office		28f. Location ( City or To	Street en	nd Number or Rura	l Route Number,	
Ö	itel or ral Dir red in								1				
	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should	Medicai	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sicien: To the best of ner: On the basis of (	examination an	e, death o	ccurred at the stigation, in my	ime, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s)	) and manner as st d place, and due to	ated. the cause(s)	
	To the within 2 To the comple	Mec	29b. Signature and title of certifler	and manner stat	ed.		29c. Licer	se number		29d. Dat	te signed (Month, I	Day, Year)	_
•	1/4		Jun ( )	AX 02 -			DOO	53337					
	10		30. Name and address of person who co	impleted cause of de	ath (Item 23a)	(Type, Pri		,,,,,,,		Jar	nuary 16,	2004	
			Dorothy Mae Seay M	1.D. 108	01 Lock	cwood	Drive	Suite 2	205, Si	lver	Spring,	MD 2090	1
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 21 200	32. Registra		9	Spark	11					
				/ /	/		/-/	dia.					

		1 - For State of Maryland /	Department of Health and Certificate of Death	Mental Hygiene 2004 03782
Ph	ysician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year  1259 0M
	Medical aminer	A. P. C. A. A. A. M. M. A. M.	4b. City, Town, or Location of Dea	
Fun Dire		5. Social Security Number 6. Sex 7. Age (In yrs. last 1		8. Date of Birth 9. Birthplace (State or Foreign
aryland	=	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location	10d. Inside City Limits
the Marylar r 28e-f show	be notified Director	Maryland Montgomery Silv	rer Spring 101. Zip Code	1 ☐ Yes 2 🕱 No
ath with	rai D	1220 East-West Highway #722	20910	USA
036 urs after dea et', or items	maminar m	3 ☐ Widowed 4 ☒ Divorced   If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "neturel", or Items 23e or 28e-f show	t, the Medical E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Sa. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Secretary	16b. Kind of Business/Industry  U.S. Government
filed Hygi	§ 0	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sumame)
should and Men	To			n Adele Wilson ural Route Number, City or Town, State, Zip Code)
ore, Mages 1 and 2 tof Health a	eny injury prother treumatic evonce.	James Philip Finn/ Friend  20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	of Disposition (Name of	ay #722, Silver Spring, MD 20910 Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item	ny injury noge.	* 4 □Donation 5 □ Other (Specify) Metro  21. Signature of Funeral Service Licensee	politan Crematory  22. Name and Address of Facility Francis J. Collins	2004 Alexandria, Virginia Funeral Home Inc.
m 202	• a	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	500 University Blv	d. W., Silver Spring, MD 20901
Physic /Med	ical	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence)	Harr Disease	Interval Between Onset and Death
Exami		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):	
8760, cate be executed physician and	buria al E	resulting in death) Last  C.  Due to (or as a consequence)	e of):	
c 68° ertificat ling phy	e as the	IF FEMALE:		
	letached for use as Physician/Me	23b. Was decedent pregnant in the past 12 morms? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 9 □ Unknown		23d. Date of delivery  Month Day Year
ords, P equires that en signed b	p pe	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Honknown
The The	page 2			24a. Was an autopsy performed?  1 \( \text{Yes} \) 24b. Were autopsy findings available prior to completion of cause of death?} \( 1 \) Yes 2 \( \text{No} \) No
of Vital Physician: 1	irector,	examiner?	Othor	ath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specify)
Vision of Attending Phys or death.	e funeral dire ation: To		b. Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred
Divis	ed in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division  To the Hospitel or Attent within 24 hours after death To the Funerel Director:	mpletely fille		lge, death occurred at the time, date and place and/or investigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)
	W	29b. Agnature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
10		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print) Canall Are The	01-16-2004 om Prer MD
Re	State egistrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	& Sparks	

State of Maryland / Department of Health and Mental Hygiene 🤈 004 03783 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 19, 2004 **Physician** ELEANOR MARIE BRACKNA 2:00 A. M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY CASEY HOUSE ROCKVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Aug. 16, 1922 Pennsylvania Director 165-20-9348 81 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f ehow Expressional be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 11621 New Hampshire Avenue, #221 United States death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White If Yes, Give Year or Dates: Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Iba M Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Schools Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wyte Marie Rosnick Dominick ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tra David A. Brackna -son 13608 Duhart Road Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 1/27/2004 Cheltenham, Maryland permit. Page Department of Important: If any injury or once. 21. Signature of Tuperal Service Licensee Donald V. Borgwardt Funeral Home, PA. auce 4400 Powder Mill Rd. Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Dementia vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No Attending Physicien: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 YOther (Specify) HOSPICE 1 ☐ Yes 2X No Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ospitel or Attend hours after death uneral Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a nd title certifier 일 D60582 January 19, 2004 Ū awa Runn 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Joyson Karakunnel, M.D. 6001 Muncaster Mill Rd. Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks JAN 21 2004 Registrar

		For State Registrar	State of N	Maryland / Dep Ce	artment ortificate			and Me		giene <sub>2</sub>	004	03	784
4 1 7.		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea Month	ath Day	Year	3. Time o	f Death
Physici /Medio	_	Mary Uveges	Borosh						Januar	y 20,	2004	4:10	A M
Examin	er	4a. Facility Name (If not institution, g			4b. City, To			of Death			unty of Dea		
		Kessler Adventis			Rocky		e If Under 2	24 Hrs	O. Data of Bird		ntgome		
Funeral		5. Social Security Number 6. 139-12-0708	Sex 7. A	Age (In yrs. last birthday 93 Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Day Oct. 3,	v. Yeari	Co	thplace (State ountry) Jersey	
Director		Usual Residence of Decedent			1				JCL. J,	1910	New	Jersey	/
/land		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside C	ity Limits
Mar	ģ	Md. Montgo	mery	Rockvil.	le							1X Yes	2 🗆 No
th the	Director	10e. Street and Number			10f. Zip C	ode				10g. Citizen	of What Co	ountry?	
th will	ai	600A Veirs Mill	Road		20	0852				Unite	ed Sta	ates	
r dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13. s?	Was Deceder	nt of His y Cuban	panic Orig , Mexican	gin? (Spec i, Puerto P	ofy Yes or No- lican, etc.)	- 14.	Race - Ame Black, Whit	erican Indian, te, etc.	
or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 2 If Yes, Give Year or Dates	OND	1 Yes 2	No No	Specify:			Sp	ecify: Wh	nite	
hour hour	d b	3 ♥ Widowed 4 Divorced  15. Decedent's			edent's Usual (	Occupat	ion				of Business		
n 72 madic	Completed	(Specify only highest g	rade completed)	(Give	e kind of work DO NOT use	done du	iring most	t of workin	g			. Vehic	1.0
with:	Ë	Elementary/Secondary (0-12) College (1-4or 5+) Clerk										ation	16
be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28e-f ehow event, the Medical Examination in a little incitile 1 at	e C	17. Father's Name (First, Middle, La.	st)			1	8. Mothe	r's Name	(First, Middle,				
uld be Aenta rked rice	To B	John Uveges					Mar	ry S1	abachul	k			
ite; Infally identified X 1X 12-00000 s 1 and 2 should be filled within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene it Health and Mental Hyglene in the Table is the Table in the Table in the Marylan in the Indillies at Indillies at the Indillies at the Indillies at the Indillies at I		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
and 2: eaith ar m 27 is her trau		Elizabeth Klanga	(Daught $\epsilon$		8 Bazze		on Pl	L. Mo	ntgome				0886
Pages 1 nent of H nut; if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	te	matory or othe	er place,	U	an. 2	24,	20c. Locati	ion - City or	Town, State	
Fant: Pa		`4 □ Donation 5 □ Other (Spec	cify)	Our Lady				2004	-	Trent		.J.	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than any injury or other freumatic event, the Magnes.	-	21. Signature of Funeral Service Lic	ensee	() ()	2. Name and			Dev	ol Fun				
40240		23a. Part1. Enter the disease, or co	molications that caus		10 East						ourg,	Md . 20	
Physician /Medical Examiner											Interval Be Onset and	tween	
* 1 * *	Je.	Sequentially list conditions if any, leading to immediate	b. Due to (or a	as a consequence of):	PI V	10-	-	d	411				
cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· c.	+200,	×19								
e be exersician ar	EX	resulting in death) Last	Due to (or a	as a consequence of):	0								
of o	dical		d	5066	wia								
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rial director, page 2 should be detached for use as the burial-transit	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2X No   9   Unknown   1   Unknown   2   Fetal death   5   Other (specify)   9   Unknown   9   Unknow								23d.	Date of de Month	livery Day	Year
s that	by Pt	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cau	ıse giver	n in Part I.		23e. Did to	obacco use	contribute to	o the cause of	death?
requires i									1 🗆 Y	res 2 N	lo 3∏Pi	robably 4	Unknown
The law require tale has been signage 2 should b	Completed										4b. Were at prior to death?	utopsy findings completion of 2 \(\sigma\) No	available cause of
Physician: The Physician: The raidirector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other			(Check only o				
Phys this or	2	1 Yes 2 No  27. Manner of Death	28a. Date of Ir				4 LI NU		e 5 Residente la R			ecify)	
fter free	tion	1 Natural 5 Pending	(Month, L	Day Year) Injury	M	o. Injury a Work?	j" es 2 □ i		ou. Describe i	iow injury oc	, and		
Attended deat ctor:	fica	3 Suicide 6 Could not	be 28e. Place of	Injury - At home, farm, s	treet, factory, o						umber or Re	ural Route Nur	n <i>ber</i> ,
after din b	Certification:	4  Homicide	building,	etc. (Specify)					City or Tox	vn. State)			
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune funeral presence.	edical C			ist of my knowledge, deas s of examination and/or i stated.									s)
To th within To th comp	Me	29b. Signature and title of certifier			29c. t	License	number			29d. Date si	gned (Mont	th, Day, Year)	
3		Minu Gan	U MD		D	11	162			Sani	1191	20,50	04
		30. Name and address of person wh	no completed cause o	of death (Item 23a) (Type	Print)		(						
		1 Gauti	19690	Doctor	· bil.	1.6	0	6.1	ducc	wŋ	IND	508.10	
Sta Registi		31. Date filed (Month, Day, Year)  JAN 23	2004	of death (Item 23a) (Type Doctor strar's Signature	ppo	eks							

State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#29c, dperMD1/20/04, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13, 6:20 P Bonnefil January 2004 Vivienne Isabelle /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** 4102 Cleveland St. Kensington Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dey, Ye May 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 □ M 2 🛛 F 252-18-0651 84 Director Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Heatth and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rati, or trams 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Maryland Montgomery Kensington Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4102 Cleveland St. 20895 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces:

1 MYes 2 1 No World
If Yes, Give
Year or Dates: War II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: White 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked Edward C. Lambert Isabelle Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Lacroix / Daughter 701 Fitzhugh Way, Alexandria, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. Jan. 17,2004 Silver Spring, MD \* 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. è Ildem MO1296 5130 Wisconsin Ave., NW, Washington, DC Xad 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aortic Stenosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? Yes 2X No certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) Residence 6 \( \text{Other} \) (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA ġ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending I Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral ( To the Hospitet 1 Conflying Physician: To the best of my movedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examples stated ion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and 29d. Date signed (Month, Dey, Year) 29b. Signature a certifies 29c. License number 10 MD 38888 1/15/04 of death (Item 23a) (Type, Print) of person Harry J. Bigham, M.D. 6410 Rockledge Dr., #200 Bethesda, MD 20817 31. Date filed (Month, Day, Year, JAN 2 0 32. Registrar's Signature Year) State 2004 garras. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** a M George Sr. Bess January 19, 2004 9:03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Mar. 3, 9. Birthplace (State or Foreign Country) Virginia **Funeral** Months 76 231-24-4165 Director Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be muitting at 1 ☐ Yes 2X No Directo Maryland Montgomery Kensington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? E S 3207 Ferndale Street 20895 USA Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1945–46 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 James R. Bess Minnie Pearl Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Bess/ Wife 3207 Ferndale Street, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State January 21 1 \* 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 2004 Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Brodley 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Coronary Artery Disease 15 years resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Hyperlipidemia and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physicien Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) be detached ☐Yes 2☐No O 9 Unknown 9 Unknown signed by Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Carotid Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Left Bundle Branch Block autopsy performed? certificate 1 ☐ Yes 2X No Hypertension or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 2 ER/Outpatient 3 DOA s after death.

Director: Alter this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L pellil Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 16360 مع 5+ (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) 6410 feekledge Dr Bothesda, mg 20817 Samuel 32. Registrar's Signature D 31. Date filed (Month, Day, Year)

JAN 23 2004 State oaks Registrar

			1 - For State Registrar	State of Mary		artment of H			giene <sub>leg. No.</sub> 2	004	03	788
7	Physici	an	Decedent's Name (First, Middle, Las					2. Date of Dea Month	Dev	Year	3. Time of	
A Ma	/Media		LOUISE F.	BIALEK		1		JANUARY			10:30	A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or ROCKV		1		inty of Death TGOMER	v	
JE 7			CASEY HOUSE  5. Social Security Number 6. Security	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti			place (State or	Foreign
	Funeral Director		579-36-9503	□ M 2□ F	3 Yrs.	Months Days	Hours Min.	DEC 9,	r, Year)	Cou	NGTON,	
1			Usuel Residence of Decedent					DEC 79	1730	MASIL	MGION,	
	how	_	10a. State 10b. County	100	:. City, Town or Lo	cation					10d. Inside Cit	-
	Ba-1 s	cto	FLORIDA PALM BEA	сн н	IGHLAND	BEACH					1 🗆 Yes	2 X No
	or 2	Director	10e. Street and Number			10f. Zip Code			l 0g. Citizen	of What Cou	ntry?	
	death with the Maryland ms 23s or 28s-f show frmst be notified at	ra E	3912 S. OCEAN BLV	D., #814  12. Was Decedent Ever	-116 10	33487	04-1-04			STATE		
_	ours after death with the Marylan ral, or Items 23e or 28e-1 ahow Exemirer must be notified at	Funerai	11, Maritaf Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)		Race - Ameri Black, White,		
5	hours after tural', or ita	by	3 ₩idowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give <b>X</b> Year or Dates:		1 ☐ Yes 2🛣 No	Specify:		Spe	cify:	HITE	
215-0036	프 클 램	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business/Industry			
Z	within 72 ene. than "na	npie.	(Specify only highest gra Elementary/Secondary (0-12)	Coflege (1-4or 5+)	life.	kind of work done of DO NOT use retired,	) )	KING				
_	filed wil Hygien other th	Con		1		HOMEMAKE	ER		OW	N HOME	<u> </u>	
land 2	S = 2 S	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,		name)		
	should ind Men marke umaric	မ	ALEC OISBOID				MINNIE	BREC				
Mary	12 sh and c		19a. Informant's Name/Relationship (7			ng Address (Street a					Code)	
	Health Fin 27		BEN M. BIALEK, So	ON 20	Db. Place of Dispo	GREAT OF	IK WAY, C	Date Date		21044 on - City or To	Num State	
Baltimore,	Pages 1 and 2 should then to the Health and Ment int: if item 27 is marked by or other traumatice		1 M Buriar 2 D Cremation 3 □	Removal from State	cemetery, crei	natory or other place	· 1			,		
	Department Department Important: any injury once.		* 4 □ Donation / 5 □ Other (Specify 21. Signature of Funeral Service Vicen			D MEM. GD				CHURC		_
n g	permit. Pag Department Important: I any injury o	li J	Hursch	Ani		Name and Addres						
			23a, Perty, Enter the disease, or comp	olications that caused the		70 ROCKVI				MD ZC	852. Approximate	
	Physician /Medical Examiner		shock, or heart fallure). List only of the shock of the s	a. METASTATI  Due to (or as a cor		IANT MELAN	AMOI			6	Onset and D	eath
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	icai Examiner	in any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor								
9	tificat ng phy as th	77										
O. Box	ires that the death certific signed by the attending p d be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of pro 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	_	ear
J.	requires that the een signed by th hould be detache		Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did tol	pacco use co	ontribute to th	ne cause of de	ath?
ds	uires sign ld be	d by						1 □ Y	s 2 TNo	3 Prob	ably 4 Ur	nknown
Ö	> 0 0	lete						24a. Was a	n 241	h Ware auto	psy findings av	vailable
Vital Hecords,	ician: The law certificate has b rector, page 2 sl	e Completed	25. Was case referred to medical					autops perform	med?	prior to cor death?	npletion of car 2□ No	use of
	Physician: this certific ral director,	To B	avaminar?	Hospitaf:	2 ER/Outpatien	t 30 DOA Othe		th <i>Check on</i> on ome 5 ☐ Reside		What (Casa)	HOSPIC	E
ō	ding Phy h. After thii funeral c		27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. injury	at	28d. Describe ho			,,100110	
<u></u>		atio	1 Natural 5 Pending 2 Accident investigation	(MONIII, Day Fea	r) Injury	Work M 1 □ Y	es 2 □ No					
Division	or in Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, streecify)	eet, factory, office		28f. Location (St City or Town	reet and Nui 1, State)	mber or Rura	l Route Numb	er,
Hos Fu		edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of my iner: On the basis of examand manner stated.	knowledge, death nination and/or in	occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the carred at the time, d	ause(s) and ate and plac	manner as st	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of codifier			29c. License	number	_ 2	9d. Date sign	ned (Month,	Dey, Year)	
	10(15)		Cestal			00¢	4121	8	1/19	104		
			30. Name and address of person who o			Print)			7			
			CHARLES HARRISON, 31. Date filed (Month, Day, Year)			ER MILL RO	DAD, ROCE	WILLE, N	(D 20	852		
	Sta Registr	_	JAN 2 0 200	32. Registrar's S	grature	Sports	/					

			1 - For State Registrar	State of Mary	land / Dep		of Hea	Ith and N			9151e. 2004	03789
	Physici /Medi		1. Decedent's Name (First, Middle, Last Golam Kadir Bhu			-			2. Date of Death January		200ar	3. Time of Death 6:28A. M
	Examir		4a. Fecility Name (If not institution, give Washington Advent	street and number) ist Hospita.	1		own, or Loc	ation of Death		4c. Cou	inty of Deeth	
	Funeral Director		5. Social Security Number 6. Se 215–49–6591 Usuel Residence of Decedent	7. Age (In	yrs. last birthday) 69 Yrs.			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Jan. 11,			elece (State or Foreign etry)
	Maryland e-f show	ctor	10a. State 10b. County  Maryland Montgome		c. City, Town or Lo		ring				1	0d. Inside City Limits 1 ☐ Yes 2 🎇 No
	th with th	al Dire	10e. Street and Number 1500 Jackson Road			10f. Zip C		20904	10		of What Coun ladesh	•
9036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-1 show ha Muical Enaminar must be notified as	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ↑ Year or Dates:		Was Decede If Yes, specif		nic Origin? (Spilexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, o cify:	
21215-0036	within 72 h ene. than "natu he Modical	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life. Farm		Occupation done durin retired)	g most of work	ing 1		Business/Inc	,
Maryland 2	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Musil 2006.	To Be Co	17. Father's Name (First, Middle, Last) Dud Mia Bhuiyan		Turn	K.I.		Mother's Name	e (First, Middle, M er Nesa			3
, Mar	and 2 sho laith and 127 is mu er trauma		19a. Informant's Name/Relationship (7)  Jahanara Begum Bhu						al Route Number. er Sprin			
Baltimore,	Pages 1 ment of He ant: If iten jury or oth		20a. Method of Disposition  12 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	ob. Place of Dispo cemetery, crer eorge Wa	sition (Name natory or oth Shingt	of er place) COn Ce	m. 1/16/	<sup>2</sup> 2004 <i>P</i>	oc. Location delph	n-City or Too Ni, Mar	wn, State Cyland
Ball	Departing Departing Important in any	l ly	21. Signature of Funeral Service Licens  Orall  Denald	Bagwa	22 D	Name and onald OO Pow	V. Bo	Facility orgwardt Lill Rd	Funeral Beltsvi	Home	P.A.	and 20705
	Physician /Medical		23a. Párt1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that daused the cause on each line.  Dye to (or as a cor	5	er the mode	of dying, su	ch as cardiac c	or respiratory arres	t,		Approximate Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of:	dit	Dice	Les	colid	IS		1 month
8760,	eath certificate be executed attending physician and for use as the burial-transit	licai Examiner	that initiated events resulting in death) Last	Due to (or as a con	nsequence of):	nde	bt C	lase	to we	ellit	VS	6 mos
.O. Box 68	0 0 0	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3□	Ectopic preg Other (spec					Date of deliver Month	y Day Year
rds, P	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions cor	itributing to death but not	t resulting in the ur	nderlying cau	se given in	Part I.	23e. Did toba 1 ☐ Yes	5.00		e cause of death?
al Record		Completed							24a. Was an autopsy performe		. Were autop prior to com death? 1 \(\sum \) Yes 2	sy findings available pletion of cause of
<del>=</del>	sician: certific irector,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	2 T F D (2 )		Other		(Check only one)			
Division of Vital	Attending Physician: r death. ector: Atter this certific. by the funeral director,	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea.	2 ER/Outpatien 28b. Time of Injury		Injury at Work?	2	ne 5 Residence 8d. Describe how			
Divis	P # F	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streedify)	eet, factory, o	iffice	2	8f. Location (Stree City or Town,	at and Num State)	nber or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at estigation, in	the time, da my opinion	ite and place, a , death occurre	nd due to the caused at the time, date	se(s) and m and place	nanner as sta , and due to t	led. he cause(s)
•	6 5 mg	2	29b. Signature and title of certifier  COCYULU	ue Hora	(mp	29c. L	icense num	229	29d	Date sign	ed (Month, D.	ay, Year)
			30. Name and address of person who co Jacquelin Honig, M 31. Date filed (Month, Day, Year)	.D. 7600 Ca	rroll Ave	enue I	akoma	Dark	Man-1	2001		
	Sta Registra		31. Date filed (Month, Day, Year)  JAN 2 1 200			Span	K	LULTY	rai yiand	2091	Z	

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of Wil	-	Certifica		Death	ivicinal riy	Reg. No. 20	04 (	3790
	Dhusis		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month		Year 3.	Time of Death
	Physic /Med		Donzel	Ε.		Betts				y 14, 200		10 PM
>	Exami		4a Fecility Neme (If not institution, giv	e street and number)			4	b. City, Town, or	Location of Deat	4c. County	of Death	
			Manor Care-Chev	y Chase			C	hevy Cha		Montgo	mery	
	Funera		5. Social Security Number 6. S		e (In yrs. last bir	thday) If Und Months	ler 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da March 2	th	9. Birthplace	(State or Foreign
	Director		235-30-4609 Usuel Residence of Decedent	I⊠M 2□F	80	Yrs.	Sujo	Trouis IVIII	March 2	0,1923 W	lest Vi	(State or Foreign rginia
•	B		10a. State 10b. County		10c. City, Town	n or Location			·		10d. In	nside City Limits
	a de la	5	Maryland Montgom	o rv	Beth							☐ Yes 2 ☑ No
	28 P	ect	10e. Street end Number	CIY	Deen		ip Code			10g. Citizen of W		
1	within 72 hours after death with the Maryland ene. than "naturel", or thems 23a or 23a-f show the Medical Examinat must be notified at	by Funeral Director	5316 Yorktown R	and			20816			United S		
:	eath	era	11. Maritel Status	12. Was Decedent E	Ever in U.S.			snanic Origin? (9			- American Inc	dian.
	9 th	5	1 ☐ Never Married 2 ☑ Married	Armed Forces?	-	If Yes, sp	ecify Cuba	n, Mexican, Puer	specify Yes or No to Rican, etc.)	Black	, White, etc.	
8	S S	,	3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ N If Yes, Give Year or Detes: [v	World	1 ☐ Yes	2 🔯 No	Specify:		Specify:	White	
<b>우</b> .	hou is in	8	15. Decedent's Ed			Decedent's He	anal Occupa	ation		16b. Kind of Bus	siness/Industry	,
21215-0020	72	jet	(Specify only highest gra	ide completed)	100.	(Give kind of w	vork done o use retired	ition luring most of wo )	rking	Nationa		
2	# 19 ki	Completed	Elementery/Secondary (0-12)	College (1-4or 5	1+)	tellige				Agen		
<b>B</b> :	H H		17. Fether's Neme (First, Middle, Last)		111	CCITIEC	IIICC II		ne (First, Middle	Maiden Sumame		
<b>a</b>	d la	Be	Fenton		tts			E11a	Connol1		•	
$\mathbf{z}$	d Me d Me d Me	2	19a. Informant's Name/Relationship (			Meiling Addro	ee /Stroot s			er, City or Town, S	State Zin Code	-1
Maryland	d 2 s	1	Lillian Latimer B							Marylan		
<b>ن</b> .	Heat Heat ther		20a. Method of Disposition	eccs/wile						20c. Location - (		
ğ	0 = 0	1	1 ☑ Burial 2 ☐ Cremation 3 ☐			Disposition (N y, crematory or			January			
<b>≒</b>	tant fury	0	4 Donation 5 Other (Specify		Westvi	ew Ceme			19,2004	Blacksbu	rg, Vi	rginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or thems 23a or 28a-f show any Injury or other treumatic event, the Medical Examinal must be notified at any lollery or other treumatic event, the Medical Examinal must be notified at once.		21. Signature of Funeral Service Licer		01356	Bethes Bethes	and Addres sda-Ch sda. M	s of Fecility Ro revy Cha: [arvland	bert A. se, Inc. 20814-3	Pumphrey 7557 Wis 501	Funer consin	al Home, Avenue
			23a. Part1. Enter the diseese, or com shock, or heart failure. List only	plications thet caused	the death. Do n						Appr	roximate val Between
آر ا	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Bilater Parkins	Due to (or as a c	onsequence of		onia			Onse	et and Death
3	nst Tag	퉅		b			n.					
<u>.</u> /	al-tre	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or as a c		1).				E I	
92	sicia b bur	8	that initieted events	c. Hypothy	TOLALSIII Due to (or es e c		١.					
ox 68760,	certificate be executed Iding physician and Ise as the burial-transit	Wedical Examiner	resulting in death) Last	Dementi	•	orisequence or	<i>j</i> .					
Вох	eath cer attendin d for use	Physician/	Dod II Other significant conditions o	antributing to death by	ut not requition in	the underking	onuno nivo	n in Part I	22h Did	Inheren Hen oan	ributo to the s	neuron of dogsth?
0	tr the de by the e	Jys.	Pert II. Other significant conditions of	ontributing to death bu	it not resulting in	the underlying	cause give	mmranı.		tobacco use cont Yes 2□ No	3 ☐ Probably	
ر ا	es that iigned b	by P							,,,,	105 ZLINO	3 Trobably	4 <u>K</u> J OHAHOWH
Records,	requir	Completed b							24a. Wes perfo	an autopsy med?	available	ion of cause
œ j	ite he	ē							101	res 2⊠No	1 ☐ Yes	2□ No
		0	25. Was case referred to medical					26. Place of Dea	ath (Check only o	one)		
> 3	S 0, 0	6	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2 ER/Out	tpatient 3 🗆 C	OOA Othe	A STATE OF THE STA	CONTRACTOR OF THE PERSON OF TH	dence 6 □Othe	(Specify)	
	eral Brail	盲	27. Menner of Death	28a. Date of Injury (Month, Dey	y 28b. T		28c. Injury Work			now injury occurre		
0	e te a	읉	1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation		1001)	njury M		es 2□No				
5	or Attending after death, Director: After I in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Inju building, etc		m, street, facto	ory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural Rou	te Number,
_	To the Hospital of Atlanding is within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	edical C		ysician: To the best of niner: On the basis of end manner stel	examination end							ause(s)
	within 2 To the	N N	29b. Signature and title of certifier	10		1 0 2	9c. License	number	-	29d. Date signed	(Month, Day, 1	Year)
<b>'</b>			kist.	Vok	e 1	1.1	D2027	4		January	16, 200	)4
	241		20 Name and address of	oompleted	neth (Itam 22-)					)	-, -00	
			30. Name and address of person who				D - 4-1		1	20017		
			Kirti Vohra, M.D. 31. Date filed (Month, Day, Year)		Ley Bou. Ir's Signature	revard,	<u>betn</u>	esaa, Ma	ryiand	20817		
	St Regist	ate trar	JAN 2 0 2		ir s Signature	9 A	oock					

			For State Registrar	State of Maryla		artment of F			ene 2001	03791
			Registrar     Decedent's Name (First, Middle, Last	st)				2. Date of Death		3. Time of Death
	Physicia		Basil Rudo	1Ph Bar	ne H			Month	Day Year	( 2135 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deatl		4c. County of Dear	th
	Lxaiiiii	CI	BROOKE GROVE REH	ARILITATION	EUN.	Sandi	Solin	4.	Martgor	not y
	Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt	thplace (State or Foreign
	Director		487-12-0384	⊠M 2□F 84	Yrs.	Months Days	Hours Will.	May 21,		isas
	D .		Usual Residence of Decedent	100	. City, Town or Lo	nation				10d. Inside City Limits
	aryla shov	_	10a. State 10b. County	100.	. Oily, Town of Ed	Cation				1 ☐ Yes 2√ No
	8a-f	Directo	Maryland   Montgon	nery	Wheaton	104 75- 0-4-		140	g. Citizen of What Co	
	with the	吉	10e. Street and Number			10f. Zip Code		100		oriti y :
	s 23c	srai	12812 Atherton Dri	12. Was Decedent Ever i	0115 13		20906	necity Yes or No-	USA 14. Race - Ame	ancan Indian
	ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ¬Yes 2 □ No	110.3.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, Whit	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW]		1 ☐ Yes 2 ☐ No	Specify:		Specify:	nite
21215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23e or 28e-f show the Medical Evantinar most be notified at	ed	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup			6b. Kind of Business	
75	n n n	pie	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor d)	rking		
5	d with	Completed	Elonionally, Sossition y (5 12)	4	Syste	ms Budget	Analyst		Army Depa	rtment
덛	e file al Hy cent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Ma	aiden Sumame)	
<u>a</u>	Ment:	70 6	Lee Barnett				Maud E	thel Nich	olas	.,.
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hydiene. Department of Healih and Mental Hydiene. Importent: If item 27 is marked other than "naturel; or Items 23e or 28e 1 show any injury or other traumatic event, the Medical Exercitor must be notified at any injury or other traumatic event, the Medical Exercitor must be notified at once.	1 3	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Number,	City or Town, State, .	Zip Code)
Σ.	and alth		Katie K. Barnett	Wife		Atherton	Drive		Maryland	
Baltimore,	Fiter of the		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	_	b. Place of Dispo cemetery, cre	matory or other pla-	сө)	Date 20	Oc. Location - City or	Iown, State
<u>Ĕ</u>	a la		`4 ☐ Donation 5 ☐ Other (Specif	y) Pe	ate of H	Cemetery		20,2004 S	ilver Spr	ing,MD
at	eparti eparti port y inj		21. Signature of Funeral Service Licer	ISBB O		2. Name and Addre		Funeral	Home, Inc	- Jan
Ш_	207 2 2 9	1. 8	(inchew)	fole	15	00 Univer	sity Bly	d.W.Sil	ver Sprin	g,MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the confidence on each line.	death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Preumo	mia					4 days
	/Medical		resulting in death)	Due to (or as a con	_ (1					(1 (
	Examiner		Sequentially list conditions,	b. Renal	Failu	re				4 days
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a con	isequence of):					
	ecute and -trans	cam	that initiated events resulting in death) Last	c Due to (or as a con	sequence of).					
8760,	cate be executed obysician and the burial-transit			200 10 (01 40 4 001)	1004201100 017.					
87	physi the	dici	•	_ d						
9 X	death certifica e attending ph d for use as th	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d. Date of de	livery
Box	eath cer attendir for use	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ l 4 □ Pregnant at time		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
P.O.	that the de ed by the detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions	contributing to death but not	t resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
g	quires n sign ald be							1 🗆 Yes	2 No 3 P	robably 4 Winknown
Vital Records,	w requi	Completed						24a. Was an	24b. Were at	utopsy findings available
Re	o = 0	Ë						autopsy perform 1 Yes 2	ed? death?	completion of cause of
ta	icien: Th certificate rector, pag	ι φ	25. Was case referred to medical				26. Place of De	ath (Check only one		2010
>	9	ToB	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA Ott	ner: 4 Nursing H	Home 5 ☐ Residen	ice 6 Other (Spe	ecify)
of	ttending Physideath. ctor: After this the funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Inju	ry at	28d. Describe hov	v injury occurred	
<u>0</u>	Attending ir death. ector: After by the fune	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigatio		.,,		Yes 2 □ No			
Division	Atte er de: ecto by th	tific	3 Suicide 6 Could not b		At home, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Ö	tel or s afte el Din	Certification:								
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Example 12 Medical Example 2 Medical Example	ny <b>sician:</b> To the best of my miner: On the basis of exam						
	the hin 24	Med	one)	and manner stated.		29c. Licens	se number	20	d. Date signed (Mont	th Day Year)
	To With		29b. Signature and title of certifier	O resear M	1.1	1 20	1793	25	a children and a	17 20011
	10+1		- Composit	7		الاد	TI	1	uncary	11,2004
			30. Name and address of person who	Mays M	(Item 23a) (Type	ce Dhilla	10. H	328 12/14	on mx	20832
	Sta	) ate	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature /	1	,		27, 1113	
	Regist		30. Name and address of person who where I are filed (Month, Day, Year)  JAN 2 0 20	104 Senero	10	sporks				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician JANUARY** 2004 04:10 A BAKER ELIZABETH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. April 10 1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Pennsylvania 1□M 2 F 77 Yrs. 165 20 8655 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State ar then "natural", or itams 23a or 28e-f show the Medical Evantinar must be notified at 1 ☐ Yes 2 No Damascus Md. Montgomery Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20872 10109 Ridge Manor Terrace, Unit C death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or its eny injury or other treumetic event, the Medical Eventral DRCE. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Specify 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 Si Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be McNamara Nora Thomas Conway 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13406 Brandon Manor Court, Mt. Airy, Md. Pamela M. Baker / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Alexandria, Virginia 1/17/04 Metropolitan Crem. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility ber Funeral Home 21. Signature of Funeral Service Licensee mirie Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER 4 Months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ned by the a P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No has 1 ☐ Yes 2⊠No page or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural 5 Pending To the Hospitel or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 16, 2004 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 18111 Prince Philip Drive, Olney, Md. Joseph Kaplan, M.D. 31. Date filed (Month, Day, Year)

JAN 2 0 2004 32. Registrar's Signature State appeara Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JANUARY 17, 2004 11:12 PM SHERMAN MTRTAM BACHRACH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min. 1 M 2 F Yrs. 1922 WASHINGTON, DC APRIL 10, Director 578-18-6181 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show the Medical Examiner must be notified at 1 ¥Yes 2 □ No CHEVY CHASE MARYLAND MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 5607 WARWICK PLACE 20815 Itema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: lited within 72 hours after 1 ☐ Never Married 2 Married ō 1 ☐ Yes 2 ▼ No Baltimore, Maryland 21215-0036 À 3 Widowed 4 Divorced WHITE 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) iring most of working Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER of Health and Mental Hygic if itam 27 is marked other r other traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental H int: If itam 27 Is marked of FELD ANNIE ၉ HARRISON SHERMAN LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6109 COUNTRY CLUB DR., EASTON, MD JOAN-LEE SLATKIN, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) ADAS ISRAEL CONG. CEM. 1/22/04 WASHINGTON, DC 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the disease, bonot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC COLITIS Physician /Medical Due to (or as a consequence of) Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) the attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 📉 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an has autopsy performed? certificate 2 No 1 💢 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ■ Anpatient 2 ■ ER/Outpatient 3 ■ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 X No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after dea To the Funeral Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 after 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY 19, 2004 D27660 30. Name and a cress of person who completed cause of death (Item 23a) (Type, Print) 10901 CONNECTICUT AVENUE, #100 KENSINGTON, MD 20895 ALPANA GOSWAMI, M.D. 31. Date filed (Month, Day, Year) JAN 22 32. Registrar's Signature Registrar

MIRIAM

ACH RACH,

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

HIM			For State Registrar	State of Maryl	_	artment of H tificate of I			iene g. No. 20	04	03794
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Jermaine B	elle				JANUARY			9:40 P <sup>M</sup>
}	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	1	4c. County	of Deeth	
			PRINCE GEORGES HO			CHEVE		T : =	-		RGES CO
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	9. Birthpla Country	ice (State or Foreign y)
1	Director		579-13-3854 Usual Residence of Decedent		30			Sep. 3,	1973	Wash	DC
	and ***		10a. State 10b. County	10c	. City, Town or Lo	cation				100	d. Inside City Limits
	Mary	ō	District of Colu	mbia		Washi	ngton				1X Yes 2 □ No
	the 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Countr	y?
	3a ol		441 - 15th St.,	N.E.			20002		Unit	ed St	ates
	death	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race	- American	n Indian,
9	after or ita		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No	i	1 Tes, specify Cuba 1 ☐ Yes 2 🙀 No	Specify:	o moan, etc.,	Specify		
8	ours irai',	d by	3 Widowed 4 Divorced	Year or Dates:							Lack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow the Madical Examiner must be rediffed at	Completed	15. Decedent's Educ (Specify only highest grade	cation a <i>completed)</i>	(Give	dent's Usual Occup- kind of work done	during most of wor	king	16b. Kind of Bu	siness/Indu	ıstry
121	vithin ne. hen	g	Elementary/Secondary (0-12)	College (1-4or 5+)	III e.	DO NOT use retired					
	filed v Hygie other t		12th 17. Father's Name (First, Middle, Last)			Fire	Fighter	ne (First, Middle, I		overr	ment
and	ntat hed of of of of	Be	Jerome B. B	0110					ine Rob		,
Maryland	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Me	ို	19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street	and Number or Ru				
Ma	ith ar lith ar 27 io 1 trau		Ernestine T. Bell		4	41 - 15t1	h St., N.	E. Wash.	, DC 2	20002	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be natified at 90ps.	3	20a. Method of Disposition		Ob. Place of Dispo	sition (Name of natory or other place	al l	Date	20c. Location -	City or Tow	n, State
Baltimore,	ages ent of ht: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		-	iemorial 1		22/04	Land	lover,	MD
Ħ	ortan injur		21. Sign ture of Funeral Service License		- 4	2. Name and Address		Stewart F			TID
ä	Deparent Deparent Important Contract Co		bohn I Day	Paul III		4001 Beni	ning Rd.,	N.E. Wa	sh., DO	200	)19
			23a. Part Enter the disease, or compli shock or heart failure. List only or	cations that caused the	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	1	Approximate Interval Between
1.2	Pnysician		Immediate Cause (Final disease or condition	Contact 9	unbot	around	to be	ad			Onset and Death
	/Medical		resulting in death)	Due to (or as a cor			•				
В	Examiner		Sequentially list conditions,	o							
- 9	p Œ	iner	if any, leading to immediate cause. Chief Orderlying Cause (Disease or injury	Due to (or as a cor	nsequence of):						
	and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	neadyonna of):						
8760,	death certificate be executed e attending physician and d for use as the burial-transit	E E		Due to (or as a con	isaquarica oi).						
87	physic	dicai		J							
9 xo	leath certific attending pl	Physician/Me	IF FEMALE:	3c. If yes, outcome of pr	regnancy				23d Date	e of deliven	,
Bo	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	,		Mor		Day Year
o.	9 = 2	isic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
0		y P	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contr	ibute to the	cause of death?
Records,	- 0 73	d by						1 □ Ye	s 2 🗖 No	3 🗌 Proba	bly 4 □Unknown
00	- Q to	iete						24a. Was a		Vere autops	sy findings available
Re	The law	Completed						autops perform	ned?	leath?	pletion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Dea	1 Yes		201103 2	
>	ysici is cer direc	ToB	examiner? 1 🔀 Yes 2 🗆 No	lospital:	2 ER/Outpatie	nt 3 DOA Oth	or	lome 5 Reside	10000000	er (Specify)	
o o	g Ph ier th	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Yes	ar) 28b. Time o	f A 28c. Injur	y at k?	28d. Describe ho	w injury occurr	ed	
<u>o</u>	ath. r: Aft	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	1/14/04	1045		Yes 2 No	Subject	shit s	elf	
Division	Atte ecto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st	reet, factory, office	100000	28f. Location (St City or Town	reet and Number, State)	er or Rural	Route Number,
Ö	ital our rs afte at Diu	Certification:		,	At	home		2701 Keating	,	ct Hei	4ts, MD
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Madicel Exami	sician: To the best of my ner: On the basis of exa							
	the h in 24 the F	ledi	one) A	and manner stated							
	To To Con	Σ	29b. Signature and title of certifier	100 N	7,	29c. Licens	o C M E		9d. Datë signed JANUARY		
^	(	)	- Ealuill	( ) A			O C PI E		J. HOMIL	10,	
N	, (1º)		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,		on Ctoo	+ Dal+4	noro M	arez lare	nd 21201
			31. Date filed (Month, Day, Year)	32. Registrar's	Signature	111 PE	in stree	t, Balti	INTE, M	атута	IN 21201
8	Sta Regist		JAN 2 2 2004	Ke a	k has	٠, م					

ORIGINAL

			For State Registrar		State of M	larylan		rtment of tificate of				Reg	ene 2 0	04	03795
	Dharaisi		1. Decedent's Name (F		•						2. Date of Month	Death	Day	Year	3. Time of Death
	Physicia /Medic		Iceline Ru	uby Bur	well						Jan.	13,	2004		20 35 <sub>р.м</sub>
5:	Examin		4a. Facility Name (If no	t institution, gi	ve street and number	7)		4b. City, Town,		on of Death			4c. County		
			Southern N	Marylan	d Hospita	1	14 - 1-411	Clint		der 24 Hrs.	9 Data et	Rieth	Princ		
	Funeral		5. Social Security Numb		Sex	62	last birthday) Yrs.	Months Days		rs Min.	_	Day, Y		Cou	
	Director	-	577-54-885 Usual Residence of De								Aug.	12,	1941	N. (	Carolina
	/land		10a. State 10	b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Man,	to	MD I	Prince	George	Up	oer Mai	lboro							1 XYes 2 □ No
	r 28e	Director	10e. Street and Number	r		-		10f. Zip Code			-	100	. Citizen of V	Vhat Cou	ntry?
	th wit	a D	12203 McCu	ıllagh				207	72			1	JSA		
	ams ams	Funerai	11. Marital Status		12. Was Deceder Armed Forces	?	.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic ban, Mex	Origin? (Spe	city Yes of Rican, etc.	No-		e - Ameri	can Indian, etc.
98	vurs after death with the Marylan rai', or Itams 23a or 28e-1 show Examir ar must be notified at	by Fu	1 Never Married		1 Tyes 2 T	•		I □ Yes 2 🏋 No	Spec	eity:			Specify	· Bla	ack
21215-0036		d b	3 ☐ Widowed 4 ☐	. Decedent's E	Year or Dates	:	163 Decer	ient's Usual Occu	nation			16	5b. Kind of Bu		
<del>1</del> 5	C 28	Completed	(Specify	only highest gi	rade completed)		(Give	kind of work done	during n	nost of worki	ng	1	o. Italy of Di	371033711	dustry
12	tiled within Hygiene. other then "	E O	Elementary/Seconda	ıry (0-12)	Coltege (1-4o	r 5+)	Comput	er Prog	ramme	er		I	Dept.	of T	reasurer
D	tile the int,	BeC	17. Father's Name (Fire	st, Middle, Las	t)				18. M	other's Name	(First, Mic	idie, Ma	iden Suman	18)	
<u>a</u>	o ta b	To B	Rufus McNe	eal					Le:	la Bel	le Ro	dge:	rs		
Maryland	s 1 and 2 should t Health and Men ttem 27 Is marke other traumatic		19a. Informant's Name	/Relationship	(Type, Print)		19b. Mailir	g Address (Stree	t and Nu	mber or Rura	l Route Nu	mber, (	City or Town,	State, Zip	Code)
	1 and 2 Health tem 27 l		William Bu	rwell/	Husband			3 McCul	lagh						
ore	00==		20a. Method of Disposi		Removal from Stat	1 6	Place of Dispo semetery, crer	sition (Name of natory or other pl	ace)		ate	20	c. Location -	City or To	own, State
Ĕ	Pa Int:		° 4 Donation 5 (	Other (Spec	ify)	Res	surrect	cion Ceme	etery	1/17	/04	(	Clinto	n, MI	)
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funer	al Service Lice	lik Ca	0		Name and Addi		 باد	rickl Camp	and Spri	Funeral	al Se	ervices 0748
X	Call Call		23a. Part1. Enter the o	disease, or con	mplications that caus	ed the deat	h. Do not ent	er the mode of dy	ing, such	as cardiac o	r respirato	ry arres	t,		Approximate Interval Between
1	Physician		Immediate Cause (Fin disease or condition	al	. ASU	15	0/4							m	Onset and Death
	/Medical Examiner		resulting in death)	(	Due to (or a	s a conseq	uence of):								1
*	Lxammer	_	Sequentially list condit	tions,	b. Hy	DOX	uence of):							m	unutes
	ed sit	niner	cause. Enter Underlying Cause (Disease or inju	ng 4	Dua to (3)	a conseq	derica or).	221112	-					301	P1.15
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Las		c. Due to (or	s a conseq	uence of):	1216	_	,				7	(av)
8760,	cate be executed physician and the burial-transit	dicai E		•	La Dic	i be	tes	, he	12	wh	DIC	le v	214	ŀ	VALUS
289	ificate g phys as the	edic		20				1	14						7000
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pr		23c. If yes, outcom			Ectopic pregnan	CV				23d. Da	e of deliv	
	the atte	sicia	in the past 12 mo 1 ☐ Yes 2 ☑ N		4☐ Pregnant	at time of d		Other (specify)				_	Мо	nth	Day Year
P.0	that the de ed by the detached	h/s	9 🗆 Unknown	i									_		
Records, 1	es De g	by	Part II. Other significa	nt conditions	contributing to death	but not res	ulting in the u	nderlying cause g	iven in Pa	art I.	1		cco use cont		he cause of death?
တ္တ	aw requir s been si 2 should	Completed										Vas an utopsy	24b. \	Nere auto	opsy findings available impletion of cause of
R	The lay ate has page 2:	E										erforme	gl?	leath?	2 No
Vital	icien: Th certificate rector, pag	Bec	25. Was case referred examiner?	to medical					26. P	lace of Death	(Check of	nly Sne)			
of V	X % D	2	1 ☐ Yes 2 📉 No		Hospital: 1 🗆 Inpa	tient 2	ER/Outpatier	I DUA		Nursing Ho	me 5□F	Residen	ce 6 □Oth	er (Specii	(y)
		ë.	27. Manner of Death	5 Pending	28a. Date of Ir (Month, I	jury Da <i>y Year)</i>	28b. Time o Injury	W			28d. Descr	ibe how	injury occur	ed	
sio	Attending r death. ector: Attending by the tune	cati	2 ☐ Accident 3 ☐ Suicide	investigati	he				]Yes 2		004	(C4	and the same	O	al Boute Musher
Division	i gite	ertifi	4 Homicide	determine	d 200. Flace of	etc. (Specil	ome, rarm, su by)	eet, factory, office	•			Town,		er or mura	al Route Number,
J	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	(Check only 2[	SCartifying F ☐ Medical Exa	Physician: To the beaminer: On the basis	of examina	owledge, deat ation and/or in	n occurred at the vestigation, in my	time, date opinion,	and place, a	and due to ed at the ti	the cau	se(s) and ma	nner as s	stated. o the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title	e of certifier	and manner	siated.		29c. Licer	nse numb	er Di	)	290	I. Date signe	d (Month	Day, Year)
	Con Twith To				0 1			~	27	71.		1	121		1
2	(a)		30 Nam	سب	o completed cause o	doath /lla	1 D	Bright)	20	100	012	121	121	0	Avenut
	(8)	-	30. Name and address	of person wh	0	da CC	. () ( e	Les	70	1000	10	I	115	5	7-0746
	Sta	ite	31. Date filed (Month,		32. Regi	strar's Signa	ature	W) I-V	1 6	VYIV	1	111	110	עיי	+11
	Regist		JAN 2	1 2004	Blown		Cook								

State of Maryland / Department of Health and Mental Hygiene

					,	Certific	ate of	Death	F	leg. No.	UL	U3	196
	Dhysiai		1. Decedent's Neme (First, Middle, Las	st)					2. Dete of Dee Month	th Dey	Yeer	3. Time of	
	Physicia /Medic		MARGARET	BASS					Ī		04	1110	70/
	Examin		4e. Fecility Neme (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County			
			MANOR CARE NUR	SING				LARGO		PRINC	E GEO	RGE'S	
	Funeral Director		579-44-794/	DM aNTE	e (In yrs. last bir	Yrs. If Un Monti	der 1 Year ns Days		8. Date of Birth (Month, Dey 2 29	7, Yeer) 1908	9. Birthp Coun VIRG	lace (State o try) INIA	r Foreign
	and and		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Tow	n or Location					1	0d. Inside Ci	tv Limits
	daryl f sho	ō	MD PRINCE (	GEORGE'S		R MARL	RORO					1√⊋ Yes	
	the 28a-	Director	10e. Street end Number	JEONGE 5	OIIE		Zip Code			log. Citizen of	Whet Coun	itry?	
	with a o		15255 CROOM AIR	PORT ROAD		10	2077	4			S.A.	,.	
	ns 2%	era	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. Was De			pecify Yes or No-		ce - Americ	an Indian.	
020	permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland Departmant of Haalth end Mantel Hygiene. Important: If Item 27 ia marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2≦ N If Yes, Give Year or Dates:	lo			Hispenic Origin? (S en, Mexican, Puerl Specify:	o Rican, etc.)		ck, White, y: BLA	etc.	
ה ה	72 ho	Completed	15. Decedent's Ed	lucation	16a.	Decedent's U	sual Occup	pation	rking	16b. Kind of B	usiness/Inc	lustry	
Ž	Med "	ğ	(Specify only highest gre- Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NO	Tuse retire	during most of world)	King				
7	og william	Š	12th			MAID				PRIVA	TE		
2	of Hy	Be	17. Father's Name (First, Middle, Last)						me (First, Middle, i	Ma <i>id</i> en Suman	ne)		
2	Mant Mant rkec afic e	2	MERRINGTON THO	MPSON				FANNIE	RECTOR				
ū	2 sho end ia me		19a. Informent's Neme/Relationship (7	Гуре, Print)	19b	. Mailing Addr	ess (Street	t end Number or Ru	ı <i>ral Rou</i> te Numbei	r, City or Town,	, Stete, Zip	Code)	
≥ .	and a salth		JANICE MASON/NIE	CE	86	18 SAP	IENZA	DRIVE F	ORT WASH	INGTON,	MARY	LAND	20744
ב כ	of He		20a. Method of Disposition 1₺ Burial 2 ☐ Cremetion 3 ☐	Pomoval from State	20b. Place of cemeter	Disposition (/ y, crematory o	Verne of or other pla	ice)	Dete	20c. Location -	City or To	wn, State	
	Peg nant int: It		4 □ Donation 5 □ Other (Specify		FT LI	NCOLN	CEMET	ERY	1-22-04	BRENT	WOOD,	MARYL	AND
5	permit. Departr Imports any Inje		21. Signature of Funeral Service Licen	See		22. Name	and Addre	ess of Facility J	. B. JENI	KINS FU	NERAL	HOME	
ם	89 E 29		6	1	-	7474	LAND	OVER ROA	D LANDOVI	ER, MAR	YLAND	2078	35
			23a. Pert1. Enter the diseese, or comp shock, or heart feilure. List only	olications that caused	the death. Do r	not enter the m	node of dyi	ng, such as cardiac	or respiretory err	est,	1	Approximate	В
	Physician /Medical Examiner	)r	Immediete Ceuse (Final disease or condition resulting in death)	e	ARDIO Due to (or as e	Pulm consequence	ind	y Fail	ure			Intervel Ben Onset and I	<b>Death</b>
	nsit	n in		b	17 per	ten	Sign	٠					
	wecu end al-trai	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	ď	Due to (or as e	consequence	of):	Litura			i		
3	ba e sician buris		ceuse. Enter Underlying Cause (Diseese or injury that initieted events	c	nan	res y	nece	i			i		
9	artificata ba executed ing physician end e as the bunal-transit	Medicai	resulting in deeth) Last	ľ	Due to (or as e o	onsequence o	f):	litus Isease			1		
<	cartif ding Ise a	Ž		d	813 he	mer	sa	sease	2				
ź	atter of for u	Physician/	David Office of the second								1	••	
į	tha d y the schec	ysi	Pert II. Other algnificant conditions co		_	the underlying	g ceuse gr	ven in Pert I.		bacco use co			/
_	that ned b		_ De	mente	4				1 4	es 2□ No	3 LI Prod	aby 4 Len	Onknown
	To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Completed by							24a. Wes e		ava	re eutopsy fi ilable prior to npletion of ca leath?	0
ב	has tge 2	Ĕ							1 □ Ye	es 20 No			/
5	Physician: The law r this certificete has b arel director, page 2 s		25. Was case referred to medical					no Disease A Disease			11	Yes 242	NO
>	sicla	o Be	examiner?	Hospitel:	•• 2□ EB/O	tnationt 2	DOA Oth	nor:	th (Check only on		(Cit	-1	
5	Phys arel d	-	27. Manner of Death	1 Inpatier	y 28b. 1	tpatient 3□ ime of	28c. Injui Woi		ome 5 Reside			)	
5	ding th.	恴	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey	Yeer) I	njury M		rk? }Yes 2∐No					
2	daa ctor	Certification:	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, fa	rm, street, fact	ory, office		28f. Location (St		er or Rure	Route Num	ber,
Š	aftar Dire	er	4 ☐ Homicide	building, etc	."(Specify)		•		City or Town	n, State)			
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edicai C	(Check only 2 Medical Exam	ysician: To the best o	examination and	, death occurre	ed at the tir	me, date end place	, end due to the corred at the time. d	euse(s) and me ate and place.	enner as ste	eted. the cause(s	)
	the the major	Med	one)	and menner ste	ted.	1							
	5 ± 5 0		29b. Signeture end title of certifier	/ Om		1,	29c. Licens	1520	2	9d. Date signe			
)	7		, , , , , , ,	<b>—</b>			2	, , , , ,		1-12	,		
_	(3)		30. Name end address of person who of BAHRAM PISHDAI	completed cause of de D. M.D. 132	eath (Item 23a) ( 8 SOUTH	Type, Print) ERN AVI	ENUE	# 310 S.E	E. WASHIN	IGTON. 1	DC 20	032	
	Sta	te.	31. Date filed (Month, Day, Yeer)		r's Signature								
	Registra		JAN 2 1 2004	Kent.	k A	met !							

DHMH 16 Rev 6/95

	1 - State of Maryland / Department of Health and N Certificate of Death	Reg. No. 4UU4	03797
Physician	1. Decedent's Name (First, Middle, Last)  Ida Mae Barbour	2. Date of Death Month Day Yeer January 14, 2004	3. Time of Death  11 P. M
/Medical Examiner	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death Suburban Hospital.  Bethesda	4c. County of Deeth Montgomery	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 79 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) 9. Birth	place (State or Foreign intry) ington, D.C.
Aaryland 1 show	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Washington		10d. Inside City Limits
office death with the Mar ritems 23s or 28s-1 st niner routified Funeral Director	10e. Street and Number 2310 Skyland Place, S.E. 20020	10g. Citizen of What Cou U.S.A.	intry?
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland as should be filed within 72 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f show eumstic event, the Medical Examiner west by notified at To Be Completed by Funeral Director	3 ☐ Widowed 4 X ivorced Year or Dates:	pecify Yes or No- p Rican, etc.)  14. Race - Amer Black, White	, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Interpretant: if item 27 is marked other than "natural", or any injury or other treumatic event, the Medical Exampones.  To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Aministrative Secretary	16b. Kind of Business/li Elementary S	
/land 2- /land be filed v Mental Hygie rinked other t attic event, III	17. Father's Name (First, Middle, Last)  Tomoc H. Tomocon	ne (First, Middle, Maiden Sumame) Ida Hillery	
Maryl nd 2 shoul alth and Ma 27 is marin r treumati	19a. Informant's Name/Relationship (Type, Print) Mr. Lawrence Stafford Jones (Son)  19b. Mailing Address (Street and Number of Ru 2310 Skyland Place, Safe W	ral Route Number, City or Town, State Z behington, D.C. 2000	ip Code)
imore, Pages 1 a nent of He sant: If item ury or othe	20a. Method of Disposition  1		Maryland
Balt permit. Depart Imports sny inji	4339 HNT PL. N.E. WAS		C.
Physician /Medical	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac block, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)	or respiratory arrest,	Approximate Interval Between Onset and Death
Examiner	Ischemic Cardianyopathy		
68760, e8760, especial as the burial-transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that injusted events resulting in death) Last  Due to (or as a consequence of):		
Box Geath cer e attendir d for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   1   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetat death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1	23d. Date of deli Month	very Day Year
S, Ss the est the bed bed bed	Part II. Other significant containons commodify to death but not resulting in the underlying dates growing at the	23a. Did tobacco use contribute to	
Recommendation of the law age 2		24a. Was an autopsy performed?  1 Yes 2 No 1 Yes	topsy findings available completion of cause of 2X No
of Vital F hysician: The hysician: The his certificate all director, pag.	25. Was case referred to medical 26. Place of Dea examiner?	ath (Check only one)  fome 5 ☐ Residence 6 ☐ Other (Spec	cify)
Alson of Vital Attending Physicien: death.	27. Manner of Death  1 XX Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  1 XX Natural 5 Pending investigation  28d. Date of Injury 1 28b. Time of Injury Work?  1 Yes 2 No	28d. Describe how injury occurred	
in Site Si	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ru City or Town, State)	ral Route Number,
ne Hospital ne Hospital ne Hospital ne Funeral to			
To the within 2 To the comple	29b. Signature and title of certifier  Apacelyman M.D. 29c. License number D27660	January 15, 20	
CR	30. Name and addless of person wyo completed cause of death (Item 23a) (Type, Print)  Alpena Goswami, M.D. 11119 Rockville Pike Rockville, Md 20852		
State Registra	31. Date filed (Month, Day, Year)  2. Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician **JAMES BOWDEN** ALTON January 15. 2004 6:00 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 105 Norair Avenue Landover Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□F 243-56-8120 42 Director 61 February 19, N. Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 ☐ No MDPrince George's Landover Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ral', or Items 23a or Examiner count be 7216 Flagstaff Street 20785 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene.
ant: if Item 27 is marked other than "natural; or Ite ury or other than that Baumain ury or other traumatic event, the Medical Equation 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced Black. Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ilea --.
Il Hygiene.
d other ther Elementary/Secondary (0-12) College (1-4or 5+) 12th Bus Driver Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Rowley Beulah Bowden ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Bowden - Wife 7216 Flastaff Street: Landover MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: any injury o Harmony Mem. Park 01/22/2004 Landover, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) \_22.Name and Address of Facility
Robert O. Freeman\_Funeral Services, 21. Signatura of Funeral Service Licensee endanbreena 1353 H Street, N.E. Washington, 23a. Part. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ERSD /Medical resulting in death) Due to (or as a consequence of): Examiner <u>Multiple Myeloma</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exam Anemia Due to (or as a consequence of): attending physicien a for use as the burial-i Box 68760, HTN Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o ihe 9 Unknown 9 Unknown ģ Division of Vital Records, P. signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bronchitis 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence XXOther (Specify2nd Home 10 1 Inpatient 2 ER/Outpatient dir 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1XX\Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Vithin 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57770 01/20/2004 30. Name vid address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane; Upper Marlboro, MD 20774 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 2 0 2004 Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year 1800 M **Physician** ,2004 JANUARY Julius G. Brooks III /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Capital Hei 6 esqu's NE 1001 JAnsen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 X M 2 □ F Yrs. 50 07 1953 DC June Director 578-70-2139 Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location Show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, in a Medical Examination and intermedial 1X Yes 2 □ No Director Capitol Heights Prince George Md 10g. Citizen of What Country? 10e. Street and Number USA <u>1001 Jansen Street</u> Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status a filed within 72 hours after du il Hygiene. other than "natural", or Item 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Smith Home Elementary/Secondary (0-12) College (1-4or 5+) Contractor Laborer Improvement and Mental Hygie Is marked other! 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Be 2 Mae Alice Johnson Julius G. Brooks Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Palmer Park Road Landover Md. 20785 Darlene Smith (Sister) 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 Removal from State Riverdale Pk Crem Jan 22 04 Riverdale Maryland \* 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St.NW emplications that caused the death. Approximate Interval Between Onset and Death er the disease of heart failure. L Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failt Immediate Cause (Final Cardes Viscolar Itea Attowsel erotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical ş IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the th 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Physician: funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Medical Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADAN 300 u81 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2004 Registrar

ORIGINAL

			For State Registrer	State of Ma	aryland / [		t of H	ealth a		ental Hy		7 11 11	4 03	800
	Physicia	an	1. Decedent's Name (First, Middle, Las	Carlson						2. Date of De Month Jan .		004 Year	3. Time o	
	/Medic	al	Edna D.  4a. Facility Name (If not institution, give			4b. City	Town or	Location o		Jan.		County of De	0020	
	Examin	er	Shady Grove A		pital			ville				lontgo		
	Funeral Director		001 10 3101	ox 7. Age □ M 2 TF	86	thdey) If Under Yrs. Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 1 (	th i <i>y, Year)</i> 6 <b>,</b> 1 9	9. B 917 Ne	inthplace (State Country)	
	/land low		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow								10d. Inside C	ity Limits
	e Mary Ba-f eh utified	ctor	Md. Montgo	mery		Rock		.е		<u> </u>				2 🗆 No
	ath with th	rai Dire	10e. Street and Number 9701 - Veirs D	rive		10f. Zip		208				USA		
920	ges 1 and 2 should be tifed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Michael Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \( \text{Yes}			gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - An Black, Wt Specify: W		
21215-0036	"natur	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usu (Give kind of wo life. DO NOT u	al Occupa	ation during most	t of working	g	16b. K	ind of Busines	ss/Industry	
2121	filed withir Hygiene. other then	omp	Elementary/Secondary (0-12)	College (1-4or 5	+) Hc	omemake		,			At	Home		
Maryland 2	ould be filed Mental Hygid arked other atto event, II	To Be C	17. Father's Name (First, Middle, Last) Edwin E. Eng							(First, Middle, Nilss		Sumame)		
	1 end 2 should Health and Men em 27 is marke ther traumatic		19a. Informant's Name/Relationship (1 Rev.Dr.Reichar		or 9	. Mailing Address 9701 - V	s (Street a	and Numbe 5 Dr.	or or Rura	Route Numb	er, City o	n Town, State , Md . 20	, Zip Code) 0850	
Baltimore,	permit. Pages 1 end Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place o cemete Glenv	f Disposition (Na. ry, crematory or o WOOD CE	me of other place emet	ery-	Jan.	20/04	Wa:	shingt	or Town, State ton, DC	
Balti	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Licen	See		Hysor	nd Addres	o., I	nc.	l Was	h	DC		
	Pnysician		23a. Part1. Enter the disease, or comshock, or heart failure. Listony Immediate Cause (Final disease or condition	plications that caused one cause on each lin	the death. Do	not enter the mod	de of dyin	g, such as	cardiac or	r respiratory a	rrest,		Approxima Interval Be Onset and	tween
	/Medical Examiner		resulting in death)	Due to (or is	a consequence	of):	2						31	, /
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as	a consequence	of):								7
o,	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):								
68760,	sate be physicial the bu	dlcai	•	d										
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	n 3 □Ectopic p 5 □ Other (s <sub>j</sub>		'				23d. Date of d Month		Year
<u>α</u>	s that t ined by e detar	y Ph	Part II. Dther significant conditions of	ontributing to death b	ut not resulting i	n the underlying	cause giv	en in Part I.		23e. Did t	lobacco	use contribute	to the cause of	death?
Records,	require sen sig sould b	Completed by	Sepsi	<u>م</u>						10	Yes 2	□ No 3 □	Probably 4 🖃	Unknown
3ec	elawi hasb ge 2 sh	mple								24a. Was auto perfo		24b. Were prior t death	autopsy findings o completion of ?	available cause of
	en: The	Be Co	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	2 Alo	1 Y	es 2□No	
Ž	Physicien: this certificated ral director, I	To B	examiner? 1 Yes 2 No		ont 2 ER/O			4 🗆 190	ırsing Hon	ne 5□Resi	idence	6 □Other (S	pecify)	
Division of Vital	ther the		27. Manne Ceath  1 Catural 5 Pending 2 Accident investigation		y Yeer)	М		yat k? Yes 2 □	No	28d. Describe				
Divis	Hospital or Att 4 hours after de Funeral Direct tely filled in by t	Certific	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	arm, street, factor	ry, office		2	28f. Location ( City or To			Rural Route Nur	nber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical Certification:	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the best niner: On the basis of and manner sta	f examination ar	nd/or investigation	n, in my o	pinion, dea	nd place, a ath occurre	and due to the ed at the time.	date and	d place, and d	ue to the cause(	s)
	with Vol	Σ	29b. Signature and title of certifier	Stel	MD	29		e number 930	00		29d. Da	te signed (Mo	onth, Dey, Year)	2064
e	(2)		30. Name and address of person who	(1)	leath (Item 23a)	(Type, Print)	/	. /	D	1	1	+	1/10 1	100
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	mary	Ur.	OVE	120	act	100	CIV	1/10	. 4
	Regist	-	JAN 2 0 2004	Men	KA	mele								
DH	IMH 17 Rev 1/2	2001		*	OR	IGINAL								

			1 - For State Registrar	State of Marylar		artment of H		Re	g. No.	004	03801
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Yeer	3. Time of Death
	. /Media			a Cheryl Coo	nbs-Mil			January	1		6:18 A. M
7	Examir	er	4a. Facility Name (If not institution, give s				Location of Death			inty of Death	
			Holy Cross Hosp		(and birth day)	If Under 1 Year	ver Spri	_		lontgo	
	Funeral Director		5. Social Security Number 578-70-5409  Usual Residence of Decedent	7. Age (In yrs.		Months Days	Hours Min.	8. Date of Birth (Month, Day, Novembe	$\frac{195}{r}$	Wasl	place (State or Foreign ntry) hington, D.C
	within 72 hours after death with the Maryland ane. then "neturel", or items 23s or 28e-f show to Medical Exercit or Last Le notified at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Mar.	to	District of Colum	bia	Washir	ngton					1X Yes 2 No
	n the	irec	10e. Street and Number		·	10f. Zip Code	*	10	g. Citizen	of What Cou	ntry?
	th wil	ai	1216 Longfellow	Street, N. W	•	200	11		Unite	d Stat	tes
	dea erre	Completed by Funeral Director	11. Marital Status	<ol> <li>Was Decedent Ever in L Armed Forces?</li> </ol>	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White,	
92	or it	J.	1 Never Married 2 Married	1 □ Yes 2 🛣 No If Yes, Give		1 Yes 2 No	Specify:			cify: B1a	_
Ö	urel',	D D	3. Widowed 4 □ Divorced	Year or Dates:							
21215-0036	"net	lete	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of wor	king t	6b. Kind o 「 <b>. S . D</b> €	f Business/In	f Health
2	withir ane. then	Ę	Elementary/Secondary (0-12)	College (1-4or 5+) years		inistrativ				n Ser	
2	filed Hygi ther		17. Father's Name (First, Middle, Last)	years	ZiGini	HISCIACI		ne (First, Middle, M	laiden Surr	name)	
Maryland	d be ental ced o	o Be	Leonard Augu	stine Coomb	s			y Lucil		rice	
<u>-</u>	mark matt	၉	19a. Informant's Name/Relationship (Ty			ng Address (Street a		<u> </u>			Code)
<u>S</u>	nd 2 ;		Leonard A. Coombs			-					o.c. 20011
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23s or 28e-f show any injury or other treumatic event, the Medical Exercities must be notified at ance.		20a. Method of Disposition	20b.		osition (Name of matory or other place				on - City or T	
Ē	ages ant of t: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval morn State		natory or otner piac ike Cremat			Relte	wille	, Maryland
Baltimore,	artme orter injur		21. Signature of Funeral Service License								
Ba	Dep any		Karnama	holy em	İ	2. Name and Addres R. N. Hort 500 Kenne	ton Compa	ny Morti	cians	, Inc.	C 20011
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea						LOIL, D.	Approximate Interval Between
8760,	American and physician and purision and purision and the burial-transit the burial-transit	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect to the conse	ion quence of):						Onset and Death
P.O. Box 687	The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of a	al death 3	Ectopic pregnancy Other (specify)				Date of delive	ery Day Year
	es tha igned be del	by P	Part II. Other significant conditions con		-	nderlying cause give	en in Part I.		_		he cause of death?
ק	w require been si should I	ted	Human Immunodef	iclency virus	S			1 ☐ Yes	2 <b>X</b> No	3 ☐ Prot	oably 4 □Unknown
I Records,	Physicien: The law rathis certificate has be rail director, page 2 sh	Completed	Drug Addiction					24a. Was an autopsy perform 1 Yes 2.	ed? X No	<ul> <li>b. Were autoprior to codeath?</li> <li>1 \( \sum \) Yes</li> </ul>	opsy findings available impletion of cause of 2 No
ā	Physicien: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					th (Check only one	)		
<u>&gt;</u>	Physic this ca al dire	2	1 ☐ Yes 2X No		ER/Outpatier		4 LI Nuising n	ome 5 Resider	ice 6 🗆 0	Other (Specif	ý)
_		Ë	27. Manner of Death 1   Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at	28d. Describe how	v injury occ	curred	
0	Attending r death. ector: After by the fune	cati	2 Accident investigation			M 1 🗆 🕆	Yes 2 □ No				
Division of Vital	P S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)			28f. Location (Stre City or Town,	State)		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medicel Exemin	sician: To the best of my kn ner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and se and plac	manner as see, and due to	tated. o the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and mariner stated.		29c. License	number	29	d. Date sig	ned (Month,	Day, Year)
	F 3 F 8		1/2-1	$\leq$				, ,	11	<b>~</b> 11	
	[~]		30. Name and address of person who op	molecular of activities	m 22a) /T		5915	1 1	1141	04	
	(5/		Catherine Godfre	y, M.D.; 1500	0 Fores		oad, Silv	er Sprin	g, Ma	ry1anc	1 20910
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0 2004	32. Registrar's Sign	ature	B,					

		_	For State Registrar	State of M	aryland /		artmen <i>tificate</i>					iene g. No.	2004	03802
	Physicia		1. Decedent's Name (First, Middle, I WILLIAM	ERNEST C	ARTER						2. Date of Death Month anuary	Day	2004 <sup>Year</sup>	3. Time of Death 1:05PM
	/Medic Examin	er	4a. Facility Name (If not institution, g Holy Cross Hosp				Sil	.ver	Location of Spring	ng			County of Death Montgor	nery
	Funeral Director		5. Social Security Number 578–54 2540  Usual Residence of Decedent	. Sex 7. Aq 1 1 M 2 □ F	ge (In yrs. last i	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, 01-09-1	Year) 941		place (State or Foreign intry) ington, DC
	e Maryland la-f show	ctor	10a. State MD Montgo	mery	10c. City, To Silve									10d. Inside City Limits 12 Yes 2 □ No
	th with th 23a or 28 ust be no	Funeral Director	700 Horton Driv	'e			10f. Zip	2090	2		10	Og. Citiz	ten of What Cou USA	untry?
980	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "netural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ▮ Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	?		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	E	4. Race - Amer Black, White Black Specify:	
Maryland 21215-0036	d within 72 ha jiene. r than *natu	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give	dent's Usua kind of wor DO NOT us Proje	rk done d se retired;	luring mos )		g	16b. Kin	nd of Business/I	ndustry Gov't
land;	12 should be filed within "h and Mental Hygiene. 7 is marked other than "traumatic event, the Me.	To Be C	17. Father's Name (First, Middle, La Francis	Carter						ers Name elen	(First, Middle, M Tolson	faiden S	Sumame)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Dennis Hawkins	o (Type, Print) Son							Route Number, 3, Germa			
Baltimore,			20a. Method of Disposition		20b. Place ceme Linco				9)	01/21			cation - City or 1 Lland, N	
Balt	Department of Important: If it any injury or or once.		21. Signature of Funeral Privice Lie	H01257		В		i 81	4 Ups	shur	Street 1		Vash, D	C 20011
8760,	Medical Ex // Medical physician and // Medical in the burial-transit	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as Due to (or as c.	Con est s a consequence Hyperli s a consequence s a consequence	ce of): pide ce of):		Fai	lure					Interval Batween Onset and Death
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2   Fetal dea at time of death	ath 3[	Ectopic pr					2:	3d. Date of deliving Month	very Day Year
	quires that n signed b uid be deta	þ	Part II. Other significant condition Hypertensic		but not resultin	g in the u	nderlying c	ause give	en in Part I				• • • • • • • • • • • • • • • • • • • •	the cause of death?
of Vital Records,	The law requinate has been single has been single 2 should l	Completed					·			_	24a. Was ar autopsy perform 1 Yes 2	4	prior to c death?	opsy findings available ompletion of cause of
/ita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only one			
n of \	ding Physician: h. After this certification funeral director,	on; To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 281	Outpatier b. Time o Injury	f 2	8c. injury Work	at :?	2	ne 5 Reside 8d. Describe ho			ify)
Division	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 200 Blace of Ir	njury - At home etc. (Specify)	, farm, str	M reet, factory		∕es 2□	-	8f. Location (Str City or Town			ral Route Number,
	e Hospitu 124 hours e Funera letely fille	edical C		Physicien: To the bes caminer: On the basis and manner s	of examination									
	To th withir comp	Me	29b. Signature and title of certifier  30. Name and address of person w	Q UX	death (Item 22	) (Type		H00	number 59837	7	29		o signed (Month 01/17/2	
			Kitanh Q.		1500	Fore	st Gl	en R	oad,	Silv	er Sprin	ng,	MD 2091	0
	Sta Registi		JAN 2 0 2004	Been 32. Regis	trar's Signature	parti								

		1	For State Registrar	State of Mary		artment of F			F	Reg. No.	004	03803
	Diam'r.		Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Margie Edith D	avis					January			8:40 P M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of	Death		4c. Co	unty of Death	
			Rockville Nursing			Rockv		M Line I a			ntgome	
11	Funeral		5. Social Security Number 6. Sex	M 21XF	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day	(, Year)	9. Birthi	place (State or Foreign ntry)
	Director		384-16-2387	86	5 113.				March 9	, 191/	Mich	1gan
	and w		10a. State 10b. County	10	c. City, Town or Lo	ocation						10d. Inside City Limits
	Maryl sho	5	Maryland Montgome	ry	Rockvi	lle						1 X Yes 2 □ No
	28a	Director	10e. Street and Number			10f. Zip Code				10g. Citizer	of What Cou	ntry?
	3a or		303 Adclare Road	d		2085	0			Unite	ed Stat	es
	death ms 2	Funeral	11. Marital Status	2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Orig	in? (Spec	ify Yes or No-		Race - Ameri Black, White	can Indian,
9	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 XNo	1	1 ☐ Yes 2 🕱 No		1 0010 11	iouri, oto.,			hite
21215-0036	ours rel',	dby	3 XWidowed 4 ☐ Divorced	Year or Dates:								
ر ک	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	9	16b. Kind	of Business/fr	ndustry
7	hen hen	du	Elementary/Secondary (0-12)	College (1-4or 5+)		ice Worke				Manu	factur	ina
N T	Hygie Hygie ther nt, m		12 17. Father's Name (First, Middle, Last)		UII.	ice worke		r's Name (	(First, Middle,			IIIg
au	ntal }	Be	Ervin Groner				Bert	tha P	otter			
$\Xi$	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Maili	ng Address (Street				r, City or To	own, State, Zi	p Code)
Maryland	d 2 s th an t7 is trau		Judith Hubbard/Da			lassbury						0878
စ်	Hea Hea tem other		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla	ce)  _	Da		20c. Local	tion - City or T	own, State
9	and and and and and and and and and and		1 X Burial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cemeter	1.0	anuar 6, 20	504	Ludir	igton,	Michigan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show important: if item 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic event, the Madical Evancian manual be notified at an once.		21. Signature of Funeral Service License	е			ss of Facility	Robe	rt A.			
ä	Ded F a		Milliam a. Lump	hier M	01173	Bethesda,	Maryl	Land	20814	• • • • •	J/ WIS	neral Home, consin Ave.,
· · ·			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	death. Do not en	ter the mode of dyi	ng, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	9	ensive He	eart Dise	ase					Onset and Death
	/Medical		resulting in death)	Due to (or as a co								
	Examiner		Sequentially list conditions, b		atory Fa	ilure						
6	Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co								
	and and I-tran	хап	that initiated events cresulting in death) Last	Pneumo  Due to (or as a co							_	
760,	te be executed ysician and ie burial-transit	calE		Dement	ia						Î	
687	9 % 9											
Box	death certificat e attending phy od for use as th	M/	IF FEMALE: 2: 23b. Was decedent pregnant	3c. If yes, outcome of p		Testonia prognana	.,			230	d. Date of deliv	
	death e atte	icla	in the past 12 months? 1 □ Yes 2 XNo	1 Live birth 2 C		∐Ectopic pregnand ☐ Other (s <i>pecify)</i> _	у				Month	Day Year
P.O.	that the de led by the a detached f	Physiclan/Med	9 Unknown	9□ Unknown								
	500	by F	Part II. Other significant conditions con	tributing to death but n	not resulting in the t	underlying cause gr	ven in Part I.					the cause of death?
ord	w require been si should l	ted					<u>-</u>		10	res 2 🗆 1	NO 3   Pro	bably 4 XUnknown
Records,	e law r has be	ompleted							24a. Was autor	sy	prior to c	opsy findings available ompletion of cause of
<u> </u>	th ate pag	S							1 ☐ Yes	rmed? 2∭ No	death?	2 □ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		0.	26. Place	of Death	(Check only o	ne)		
of	this aldi	2	1 ☐ Yes 2 X No  27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatie	IN 3 DOA	4 MINUI	-	e 5 🗌 Residente Residente 1		Other (Spec	ify)
n	fing f	lon	1 XNatural 5 ☐ Pending	(Month, Day Y	ear) Injury	Wo	irk? ]Yes 2 □1		od. Doscribo	iow injury c	,0001140	
Division	or Attending Fafter death. Director: After in by the funer.	fica	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, si						Number or Ru	ral Route Number,
DΪ	after after Direct	Certification;	4  Homicide	building, etc. (	Specify)	,			City or To	vn, State)		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	edical C		sician: To the best of r ner: On the basis of ex and manner states	amination and/or in							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0		29c. Licen	se number			29d. Date s	signed (Month	, Day, Year)
	10		Morrus	V.1084	M.	D47	330			Janua	ry 20,	2004
			30. Name and address of person who co									
	··		Thomas V. Joseph,		West Edm	۵		207,	Rockvi	lle,	MD 20	852
	St Regist	ate rar	JAN 22 201	32. Registrar's	s Signature	Spork	2					

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2004 Robert Dean Dikkers **Physician** January 17, 4:20 AM /Medical 4c County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1⊠M 2□F 73 Jan. 19, Illinois 319-24-9113 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28a-1 show may intry 90 other traumatic event, if a Medical Examinar must be rediffied a once. 1 ☐ Yes 2 ☑ No Bethesda Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 9309 Singleton Drive by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1954–1956 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Civil Engineer 5+ 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Margaret Piltz John Dikkers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9309 Singleton Drive, Bethesda, Maryland 20817 Caryl M. Dikkers/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition January 23, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Chase, Inc. 21. Signature of Funeral Service Licenses 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finaf disease or condition PNEUMONIA ASPIRATION Pnysician DAY resulting in death) /Medical Due to (or as a consequence of): Examiner MONTHS CEPERRO ARCI DENT VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to for as a consumence of: g physicien and as the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending IF FEMALE: nse n 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy 2 Fetal death 1 Live birth Month Year Day ĺ 4 Pregnant at time of death 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 2 PNo certificate 1 Yes director, 26. Place of Death Check onl. one Be 25. Was case referred to medical examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To this After thi 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death Medical Certification: Injury 1 Naturai 5 Pending To the Hospitel or Attending within 24 hours after death.

To the Funeral Director: All completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 19, 2004 D36552 Talyon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) focusile MD. 20862 Drive # 401 50 W. Edmonston 1. Talwar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 22 2004 Registrar

DHMH 17 Rev 1/2001

ROBERT, D. 11,7104 4:30 AM

DIKKERS

			Flease	Type of Prin					-				
			1 _ For State	State of Ma	arylan	,			mentai Hy	giene	200	1. 000	005
			Registrar			Cei	tificate of	Death		Reg. No.	L U U	7 001	JUJ
	Physici	an	1. Decedent's Name (First, Middle, La				<b>~</b>		2. Date of De Month	ath Day	Yeer	3. Time of	
	/Medic		MARGARET	GEIB			DODZO		Linuar	7.1	200		-/2 M
20	Examin	er	4a. Fecility Name (If not institution, gir		- 10	,	4b. City, Town, o	r Location of Deat	h	d 4c.	County of De	ath	
				plans Ho	SPIT		If Under 1 Year	MIRE C	1 February Bir	*5	0.0	dholone (Ctate o	- Comina
	Funeral Director		5. Social Security Number 6/3	1	. ,	ast birthday) 2 Yrs.	Months Days	Hours Min.	8. Pate of Bir Month, Pa Feb. 14	Year)	1 W	rthplece (State of Journaly) ashingto	roreign nn D C
			214-36-4985 Usual Residence of Decedent					<u></u>	TCD. 1			abilingee	11,0.0
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside Cit	y Limits
	Mar Mar	to	Maryland Montgom	ery		Bur	tonsville	<u> </u>				1 🗆 Yes	2 <b>X</b> No
	ours after death with the Maryland rel', or Itema 23e or 28a-f show Exacities roust be notified at	Directo	10e. Street and Number 14621 Old Columb	ia Pike			10f. Zip Code 2086	6-0028			zen of What C		
	na 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.	S. 13	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	)-	14. Race - An	nerican Indian,	
_	r Itan	표	1 ☐ Never Married 2 ☐ Married	Armed Forces?			Was Decedent of H If Yes, specify Cuba	an, Mexican, Puen	to Rican, etc.)		Black, Wh		
ž	urs a	by	3 □Widowed 4 □Divorced	1 □Yes 2√□N If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ No	Specify:			Specify: W	hite	
5-0036	within 72 hours after ene. then "naturel", or Ite	ted	15, Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occup	nation	rkina	16b. Ki	nd of Busines	s/Industry	
Z	thin .	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retired	d)	iking	Mor	tgomer	y County	7
7	filed wi Hygien Sther th	Completed	12			Scho	ol Teache				olic Sc	hools	
nd	of a b	Be	17. Father's Name (First, Middle, Las F. Ellsworth G	,					me <i>(First, Middl</i> e et Marie				
<u>X</u>	should I	ို											
Maryland 2121	2 sh and Is m		19a. Informant's Name/Relationship				ng Address (Street						2066
	and lealth m 27 her t		James G. Dodson,	SrHusbai		A STATE OF THE PARTY OF THE PAR	Office B					ryland20	1866
0	Pages 1		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [	Removal from State			sition (Name of matory or other place	ce) 1 /20	Date /2004			r Town, State	
E	tant:		*4 Donation 5 Other (Speci		OIL		metery					le,Maryl	land
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke eny injury or other treumstic once.		21. Signature of Funeral Service Lice	Sacra	A	D	2. Name and Addre Onald V. 400 Powde	Borgward	t Funera	al Ho	me, P.	A.	1705
	20		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death						Cy PRIL	Approximate Interval Bety	•
Ų,	Physician		Immediate Cause (Final	Sepsi								Great and D	Death
	/Medical		disease or condition resulting in death)	a. Due to (or as:		uence of):						11 aug	<u> </u>
	Examiner				,								
3		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):							
	cuted nd ransi	Examiner	that initiated events	c									
o Î	e be executed sician and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):							
1760		Icai		_ d									
89	ntifica ng pt	Jed	IF FEMALE:		S - 65 (60 II)					- 1			920
Box	death certificate b attending physic of for use as the b	Physiclan/Medl	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	v		1 3	23d. Date of d		·
Ш	dea he att	sicla	in the past 12 months?	4□Pregnant at 9□Unknown			Other (specify)	,			Month	Day Y	'ear
P.O.	at the	h	9 Unknown										
ś	uires that the de i signed by the a id be detached f	by	Part II. Other significant conditions	contributing to death be	ut not res	ulting in the u	nderlying cause giv	ren in Part I.				to the cause of d	
ב	w requir been si should	ted							1 🗆	Yes 2	1N0 31X1	robably 4 DU	Inknown
Ö	law r as be	Completed							24a. Was		24b. Were	autopsy findings a completion of ca	ivailable
<u> </u>	The ate h page	Ь								ormed? 22 No	death'	s 20 No	
Ħ	ctor.	Be (	25. Was case referred to medical examiner?			-022		26. Place of De	ath (Check only				
<u></u>	hysic his ce I dire	2	1 ☐ Yes 2 XNo	Hospital: 1 X npatie	ent 2 🗆	ER/Outpatie	nt 3 DOA Oth	ner: 4 ☐ Nursing H	Home 5 ☐ Res	idence (	6 □Other (Sp	ecify)	
0	ng P		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju- (Month, Day	ry y Year)	28b. Time o	f 28c. injui Wor	ry at rk?	28d. Describe	how injur	y occurred		
Division of Vital Records,	eath. or: A	Certification;	2 ☐ Accident investigate				M 1 🗆	Yes 2 ☐ No					
≥	or Att	Ē	3 Suicide 6 Could not determine		ury - At ho c. (Specif	ome, farm, st y)	reet, factory, office		28f. Location ( City or To	Street an wn, State	d Number or i )	Rural Route Numi	oe <i>r</i> ,
	urs af			1					1				
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner sta	f examina	wledge, deat tion and/or in	h occurred at the till vestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	date and	and manner: place, and d	as stated. Le to the cause(s)	
	ro thin	Me	29b. Signature and title of certifier				29c. Licens			29d. Dat	e signed (Mo	nth, Day, Year)	
	10		David Lim	M.D.			RE	5-000		MAT	JARY I	5,2004	
	(0		30. Name and address of person who		leath (Iten	п 23а) (Туре,	Print)	0115111	205 14	104.	(Tlai	112 127	
			DAVIO LIM 6  31. Date filed (Month, Day, Year)	00 NORTH  32. Registra			STREET,	RALIM	UKE , MI	th [ UA	· ・ ・	2128/	
×.	Sta Regist		IAN 2.1.2		مصرر	9	Souk	2					

		1 - State Registrar		ryland / Dep <i>Ce</i>		of Health a		Reg. N	///////	0 3 8 0
Physici /Medic	cal	Decedent's Name (First, Middle, Last     Eleanor     4a. Fecility Name (If not institution, give	H. Dixon		4b. City, To	own, or Location of	Janu	thry 15,	2004 Year	3:20 A. M
Examir Funeral		Prince George's Hospi. 5. Sociel Security Number 6. Se	tal Center	(In yrs. last birthday	If Under 1	Cheverly Year If Under	7	of Birth	Prince Geor	place (State or Foreign
Director		Usuel Residence of Decedent	]м 2€.	89 Yrs.		Days Hours	Febru	mry'21,	1914   Norti	Carolina  10d. Inside City Limits
death with the Maryland me 23e or 28a-f show rrougt be nutified at	ctor	Maryland Prince Geo	nge's	10c. City, Town or L		Glenar	den			1XXYes 2 ☐ No
th with th	Funeral Director	10e. Street and Number 7903 Dellwood Aven	ue		10f. Zip C	2	20706		U.S.A.	
urs after dea al', or Iteme ixe officer m	þ	11. Marital Status  1 Never Married 2 Married 3 Woldowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2	_	igin? (Specify Yes n, Puerto Rican, e	s or No- tc.)	14. Race - Amer Black, White Specify: BLac	, etc.
2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-1 show aumatic event, it a Medical Exeminating the nutitied at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	ucation de completed) College (1-4or 5-	(Give	edent's Usual e kind of work DO NOT use	done during mos retired)	st of working		Kind of Business/line On Aging	
uld be filled whental Hygierked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Luther Hairs	tan	·		18. Moth	er's Name (First, I Earline (	akes		
nd 2 shoulth and h		19a. Informant's Name/Relationship (7 Mrs. Eleanor J. Johnson	ype, Print) n(Daughter)	19b. Mai 7903	ing Address (i	Street and Numb d Avenue (	er or Rural Route Henerden,	Number, City Marylan	or Town, State, Z d 20706	ip Code)
permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked enty injury or other traumatic es once.		20a. Method of Disposition  (XSBurial 2 Cremation 3 Companies Solution 5 Other (Specify 21. Sonature of Funeral Service Licen	)		morial (	o of her place) Cemetery Address of Facili		2004	Landover, N	Maryland
Depar Impo		23a 11. Enter the disease, or composite, or heart failure. List only	blications that caused one cause on each lin	the death. Do not ele.	nter the mode	of dying, such as	WASHINGIC cardiac or respira	N. D.C.	L HOME, IN _20019	Approximate Interval Between Onset and Death
/Medical Examiner  thysicien and the parial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Resp. Due to (or as a construction of the c	a consequence of):  Chive a consequence of):  Third a consequence of):	Ins. Hear	officer	iner .			
that the death certificate ed by the attending phy detached for use as the	Completed by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pre □ Other (spe				23d. Date of deli Month	very Day Year
e law requires that the has been signed by th ge 2 should be detache	d by Ph	Part II. Other significant conditions of Sensi's	ontributing to death bu	ut not resulting in the	underlying ca	use given in Part	I. 23	e. Did tobacc		the cause of death?
e law has b	complete	preumonia muti organ	Failuer					a. Was an autopsy performed	prior to death?	topsy findings availal completion of cause of 2 🔯 No
iclan: certific	Be	25. Was case referred to medical examiner?	Hospital: 1 Unipatie	int 2□ ER/Outpati	ent 3 DOA	Other	e of Death (Check		6 ☐ Other (Spec	eifv)
Attending Phy or death. ector: After this by the funeral d	atlon; To	27. Manner Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day			3c. Injury at Work?	28d. De	scribe how in	njury occurred	
al or Atters after de l'Directo	I Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc				City	y or Town, St		
urs urs aral	edical		niner: On the basis of and manner sta	examination and/or	investigation,			e time, date a	and place, and due	to the cause(s)
to the Hospital vithin 24 hours a to the Funeral isompletely filled	Me	29b. Signature and title of certifier								
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Me	29b. Signature and title of certifier  30. Name and address of person who	completed cause of d	eath (Item 23a) (Tvo	e, Print)	005	4794	. 0	1/16/2	2078S

			1 - For State Registrar	State of Maryla		artmen rtificat			nd M		giene Reg. No	200		03808
	Physici /Medic		1. Decedent's Name (First, Middle, Las Lawrenc	e A. DiBar	i, Jr.					2. Date of De Month Januar	y 15	, 200		3. Time of Death $12:30 \text{PM}^{\text{M}}$
	Examir	er	4a. Facility Name (If not institution, give 11905 Piscataway	Road		4b. City, Clin If Under	ton	Location of			Pr	ince	Geor	
	Funeral Director		5. Social Security Number 6. S 579-52-4203  Usual Residence of Decedent	ex PDXM 2□F	rs. last birthday) 65 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Oct. 17	, 193	8 W	Count ash	ace (State or Foreign try) Lngton, D.(
	72 hours after death with the Maryland Insture!, or items 23a or 28a-1 show dical Examities must be notified at	Director	10a. State 10b. County Maryland Prince ( 10e. Street and Number 11905 Piscataway	Georges Cl	City, Town or Lo	10f. Zip	Code 0735				10g. Cit	izen of Wh		0d. Inside City Limits 1 ☐ Yes 2 ☑ No iry?
9003	hours after death with the Marylan turel', or items 23a or 28a-1 show at Examiner must be notified at	d by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 195	51-72	1□Yes :	260kNo	Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)		14. Race -	White, e	etc.
Baltimore, Maryland 21215-0036	be filed within 72 ho ital Hygiene. id other than "netui event, ITe Maylcal	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life. Milit		al Occupa rk done d se retired)	uring most		ng (First, Middle,	U.	S. Na		ustry
rylanc		To Be	Lawrence Aloysius  19a. Informant's Name/Relationship (7)		10h Maili	na Address		Cece1	ia	Dea	ver		4- 7-	0.41
ore, Ma	s 1 and 2 s of Health ar item 27 is r other trau		Christopher DiBar:  20a. Method of Disposition  1 Burial 200 Cremation 3	i. / Son 20t	11905 cemetery, cree	Pisc esition (Nam matory or o	ataw ne of ther place	ay Rd	., C	linton	, MD 20c. Lo	2073 ocation - Cit	5 ty or Tov	vn, State
Baltim	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Life on		las Cre Ge 61				16/2 Fune d.,	004   ral Ho Oxon H	Edge me ill,	water P.A. MD 2	, МІ 0745	5
	Pnysician /Medical Examiner		23a. Part1. Enter he disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	fications that caused the done cause on each line.  a	and	,		Can			rrest,			Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and ind for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons d.										
P.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pro						23d. Date o Month		y Day Year
	requires een sign nould be	þ	Part II. Other significant conditions co	ontributing to death but not i	resulting in the u	nderlying ca	ause give	n in Part I.		1 🗹	res 2[	□No 3[	□ Proba	cause of death?
tal Rec	The la ate has page 2	e Completed	25. Was case referred to medical								rmed 2 No	24b. Wer prior deat 1	r to com th?	sy findings available pletion of cause of
Division of Vital Records,	ding Phys h. After this funeral di	ToB	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		A Other	r: 4 🗆 Nurs	sing Hom	(Check only only only only only only only only	ience 6		Specify)	
Divis	i Pite o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, larm, str	eet, factory,	, office		2	8f. Location (S City or Tow			or Rural i	Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	<b>l</b> edicai	one)	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	estigation,	in my opi	nion, death	place, ai occurre	nd due to the o	cause(s) date and	and manne place, and	or as stated	ted. he cause(s)
	To with	Σ	29b. Signature and title of certifier	lelh			A (	) 23 (	686		_	e signed (Mary 1		
2			30. Name and address of person who of Brian Heller, M.D.	· 1050 W. Per	imeter	Rd.,#	BB-5	0, An	drew	s-A.F.1	В	MD-20	762	
	Sta Registr		JAN 2 0 2004	32. Registrar's Sig	nature	e l					- ,		J	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Zepha January Irene Dwyer 17, 2004 12:28p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Casey House Montgomery Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Director 577-20-6800 83 12, 1920 Washington; DC Dec. Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be coulded at 1 Yes 2 No Directo Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 42nd Avenue <u>United States America</u> Funeral Peges 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or Items 23 ant: If ye other traumatic event, it is marked other than "natural; and uny or other traumatic event, it is much call and uny or other traumatic event, its much call and an uny or other traumatic event, its much call and an unit or other traumatic event, its much call and an unit or other traumatic event, its much call and an unit or other traumatic event, its much call and an unit or other traumatic events. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 1 No Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Geographic 12 Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Edward Crane Zepha Roles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene J. Purdy/Daughter 6528 Quiet Hours Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/20/2004 Brentwood, Maryland 21. Signatura Fundral Service License Fort Lincon Funeral Home 3401 Bladensburg Road Brentwood, Maryland 20722 2 Mon 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Cardiopulmonary Disease /Medical resulting in death) Due to (or as a consequence of): Examiner Leukemia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 🙀 No by the a 9 Unknown 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. tx Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? s certificate has irrector, page 2 1 ☐ Yes 2 ☑ No 1 Yes 21 No or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other:  $_{4}$  \subseteq Nursing Home  $_{5}$  \subseteq Residence  $_{6}$  \subseteq Other (Specify)  $_{Hospice}$ ٩ 1 ☐ Yes 2 🔀 No funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; After 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Pelli the Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lambda Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and magner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60582. lunne 1/17/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joysøn Karakunnel – 6001 Muncaster Hill Rd Rockville, Md 20850 31. Date filed (Month, Day, Year) State JAN 2 0 2004 Registrar

			1 - For State Registrar	State of M				t of H	ealth a		lental Hy		004	0381	Contract of the Contract of th
	Physic	an	1. Decedent's Name (First, Middle, L.	·				-	-		2. Date of De	ath Day	Year	3. Time of Death	
	/Medi			odson							Januar			1:45 a	М
Ì	Examir	ner	4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location o	of Death		4c. Cou	unty of Deat	h	
			Anne Arundel Med						polis				e Aru		_
	Funeral			Sex 7. Aç 1 ☐ M 2 ☒ F	ge (In yrs. 79	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birt	hplace (State or Forei untry)	gn
	Director		Usual Residence of Decedent			7 113.					Feb. 24	4 <b>,</b> 192	4  Wasl	nington, D	C
	I be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "naturel", or items 23a or 28a-f show event, I'ze Medical Exercitres result be notified at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limit	ts
	Mary -f sh	ţ	Maryland Prince	George's		W	est H	yatt	svill	Le				1⊠Yes 2□N	10
	28a	Je C	10e. Street and Number				10f. Zip					10g. Citizen	of What Co	untry?	-
	38 ol	0	3105 Kimberly R	oad				20	782			U.S		•	
	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "nature!, or items 23s or 28s-f show aumatic event, it a Medical Exercities are a political exercities.	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. \	Vas Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		Race - Ame	rican Indian,	-
9	or ite	₹	1 ☐ Never Married 2 ☐ Married	Armed Forces						, Puerto	Rican, etc.)		Black, White	e, etc.	
<u> </u>	rel',	1 by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2	LALNO	Specify:			Spe	ecity: Wh	nite	
2-0	72 h natu	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced	lent's Usua kind of wor	l Occupa k done d	ition uring most	of worki	na	16b. Kind o	f Business/	Industry	
2	ithin Jen Man	Jdu	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT us	e retired)			. •				
2	led w lygier her ti	S	12			Banc	uet V	laitı					raton		
Ē	be fil tal H d oth	Be	17. Father's Name (First, Middle, Las								(First, Middle,	Maiden Sun	name)		
7	should in and Meni	ဥ	, , , , , , , , , , , , , , , , , , ,	Carll		7			The		Pyles				_
Maryland 21215-0036	2 sh and Is m		19a. Informant's Name/Relationship								l Route Numbe	_		lip Code)	
<u>ح</u>	1 and 3 Health tem 27 other tr		Robert Ray Dodsor	5011	00h B						rofton		21114		_
5	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 [	☐Removal from State	20b. P	lace of Dispo emetery, cren	sition (Nam natory or ot	e of her place	)	D	ate	20c. Location	on - City or	Town, State	
Ē	ment: ment: lant:		*4 ☐ Donation 5 ☐ Other (Spec	fy)	For	t Lincol					/2004	Brenty	wood,	Maryland	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke eny injury or other traumatic 2008.		21. Signature of Funeral Service Lice	nsee Danch Jar	en en en en en en en en en en en en en e	47	Name and	Addres:	s of Facility	Gaso Aveni	ch's Fu ue, Hya	neral ttsvil	Home,	P.A. D 20781	
on of Vital Records, P.O. Box 68/60,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed TE T T T T T T T T T T T T T T T T T T	Certification; To Be Completed by Physician/Medical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. End Sta Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death be Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	a consequence of pregna 2 Fetal time of definition of the consequence of pregna 2 return of definition of the consequence of pregna 2 return of definition o	uence of):  uence of):  uence of):  ncy death 3 =	Ectopic pre Other (spe derlying ca	ognancy cify)  use give  a Other Conjury Work' 1  Y	n in Part I.  26. Place c  - 4 □ Nur at ? es 2 □ N	of Death sing Hom 2 lo	23e. Did to 1 24a. Was putto 1 Yes (Check only o	23d.  obacco use of set 2 \( \text{No} \)  an 24  sy sy sy sy sy sy sy sy sy sy sy sy sy s	b. Were aut prior to co death? 1 Yes  Other (Special Special S	the cause of death?  bably 4 (Munknown opsy findings available ompletion of cause of 2 (No note Number, al Route Number,	e
	To the Hospit within 24 hours To the Funere completely fille	edical (	29a. Certifier (Check only one)  1 ☑ Certifying Pl 2 ☐ Medical Exa	nysician: To the best miner: On the basis o and manner st	t examinat	wledge, death ion and/or inv	occurred a estigation, i	t the time in my opi	e, date and nion, death	place, a	nd due to the o	cause(s) and date and plac	manner as : e, and due !	stated. to the cause(s)	
	To ti withii To ti comp	N	29b. Signature and title of certifier		,		29c.	License	number			29d. Date sig	ned (Month,	Day, Year)	
			( Conthal.	/ Quell	Δ	MIN		D005	2555			Januar	y 22.	2004	
1	(5)		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type, F	Print)		<del></del>						_
- (			Gabby Fossett, M	D., 6525	Be1cr	est Ro	ad, S	te.	150,	Hyat	tsvill	e, MD	2078	2	
	Sta Registr	_	31. Date filed (Month, Day, Year)  JAN 2 3 2004	32. Registr	ar's Signat	Speed .	e								

		State of Maryland / Department of Health and Merchant State of Maryland / Department of Health and Merchant State Registrar Certificate of Death	ental Hygie Reg. 2. Date of Death	
Physic /Med Exami	cal	Catherine C. Deane  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Month	Day Year 6 04 8:14 A 4c. County of Death
Funeral Director		Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 02 21 1	
the Maryland 28a-f show	rector	10a. State         10b. County         10c. City, Town or Location           D. C.         Washington           10e. Street and Number         10f. Zip Code	10g.	10d. Inside City Limits 1 ★ Yes 2 No  Citizen of What Country?
ife, Marylatin ZIZIO-000  s 1 and 2 should be filed within 72 hours after death with the Maryland fleath and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Evaninar must be notified at	Completed by Funeral Director	11. Marital Status	Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black  b. Kind of Business/Industry
Maryiarid 4.14.15-0050 nd 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 is marked other than "natural", or rtraumatic avant, the Medical Everni	To Be Comp	College (1-4or 5+) 3 yrs. Supervisor of Bacteriolo  17. Father's Name (First, Middle, Last) Charlie Crawley Sarah Wi  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	ogy HO (First, Middle, Mail	
t. Page rtment o rtent: if		Karen W. Atkins Niece 5409 Arnold Drive, Lanh  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 1-24- 21. Signature of Funeral Service Licensee	-04 La	ndover, MD.
Pnysician /Medical Examiner		23a. Paril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		The second secon
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	900	acuse gas
the death certifice by the attending pt tached for use as It	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑Unknown
The The ate h page	e Completed			24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Phys rthis ral dii	To B	27. Manner of Death    Second	ne 5 Residence 8d. Describe how	
Hospitel or 4 hours afte Funeral Dir iely filled in t	edical Certification;	4 Homicide building, etc. (Specify)  29a. Certifier (Check only 2 Medical Faminer: On the basis of examination and/or investigation, in my opinion, death occurred	City or Town, S	se(s) and manner as stated.
To this I	Med	29b. Signature and title of certifier  29c. License number  29c. 29c. 20c. 20c. 20c. 20c. 20c. 20c. 20c. 20	290	Date/signed (Month, Day, Year)
S Regis	tate	30-Name and address of person who completed eause of beath (Kejh 23a) (Type, Print)  UYINGEY  31. Date filed (Month, Day, Year)  JAN 2 3 2004  32. Registrar's Signature	ver A	arkway, MD, 20

DHMH 17 Rev 1/2001

ORIGINAL

0 - 00000		-
Eileen M	Evans	

State of Maryland / Department of Health and Mental

Hygiene Reg. No.	2	n	n	1.	0	2	Q	ļ	
Reg. No.	۲	U	U	-	U	J	Ü	1	ļ

	_1	Stete Registrar			Ce	rtificate of L	Death		R	eg. No.	004	03812
		1. Decedent's Name (First, Middle, Las	t)	-					2. Date of Dear Month	h Day	Year	3. Time of Death
Physiciar /Medica		Eileen McKen	na Evar	ıs					January	19 20	04	1605 p <sup>M</sup>
Examine		ta. Fecility Name (If not institution, give		n <i>ber)</i>		4b. City, Town, or		of Death			ity of Deeth	
		Suburban Hospita				Bethe	sda If Under	24 Ure	0.0		tgome:	
Funeral Director		132.38.6038	ex □ M 2XXF	7. Age (In yrs. 57	/ast birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Sept. 18	,1946		place (State or Foreign htry) Jersey
and **	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation					1	Od. Inside City Limits
Ba-f sho	Director	DC			Washi						(118)	1 ☐ Yes ŽŽNo
th with th		10e. Street and Number 3900 Cathedral Av	enue, N	I.W.		10f. Zip Code 20016					.S.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating the notified at one of the traumatic event.	by runeral L	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 X No /e		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Ori n, Mexicar Specify:	igin? (Spe n, Puerto l	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, hify: Wh	
2 hou	2	15. Decedent's Ed			16a. Dece	dent's Usual Occupa	ation	a make community to		16b. Kind of		
thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	e kind of work done of DO NOT use retired tive Direc	)	t of workii	.  1			lta Honor
ed will ygien t. the	5		+4		LXeCu	cive bite						Internation Inc.
Id be fill the both the control of t	0 00	17. Father's Name (First, Middle, Last) Francis McK							(First, Middle, i et Cadie		ame)	
should Mumat	1	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ing Address (Street a	-	-	_		m, State, Zip	Code)
and 2 alth a 27 to		William Evans, Jr	./Husba	ınd	3900	Cathedra	L Ave	nue,	N.W. Wa	shing	ton DO	20016
S T T T T T T T T T T T T T T T T T T T	1	20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from	20b. F	Place of Disponentery, cre	osition (Name of matory or other plac	θ)	D	ate	20c. Location	- City or To	own, State
Pag ment ent: t		*4 □Donation 5 □ Other (Specify		Mer	norial				4,2004 N			
permit. Depart Import any inj		21. Signature of Funeral Service Licen	Bon	/	5	2. Name and Addres	s of Facilit	y Jose Aveni	eph Gawl ie, N.W.	er's Wash:	Sons, ington	Inc. DC 20016
		23a. Part1. Ent * the disease, or com shock or heart failure. List only	olications that c	aused the deal	th. Do not en	ter the mode of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_		infu	nes						Onset and Death
/Medical		resulting in death)	Due to	(or as a consec	- (1							
Examiner		Sequentially list conditions,	b. Due to	or as a consec	tuanca of):							
led sit	line	if any, leading to immediate cause. Enter Underlying	D00 10 1	or as a consec	(derice of):							
al-trar	Examiner	that initiated events resulting in death) Last	C. Due to (	(or as a consec	quence of):							
e be ey sician buria			d									
g phys	Medical											
	Physician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		oirth 2 ☐ Fete nant at time of c	el death 3	□Ectopic pregnancy □ Other (specify)					Date of delive Month	ery Day Year
ires that signed b	2	Part II. Other significant conditions of	ontributing to de	eath but not res	sufting in the u	underlying cause give	en in Part I	l.	23e. Did tol	A.C.	ntribute to th	ne cause of death?
law requires tas been signed as been signed.	ere								24a. Was a	n 24h	Were auto	psy findings available
	Completed								autops	y	prior to con death?	mpletion of cause of
icien: 'icien: 'sertifica	n D	25. Was case referred to medical examiner?	Hospital:			Othe	20-		(Check only on			-
o	2	1 XYes 2 ☐ No 27. Manner of Death	28a. Date		28b. Time of	HI SLADOA	4   141		ne 5 🗌 Reside 28d. Describe ho			y)
or Attending after death. Director: After in by the fune	Certification:	1 □Natural 5 □ Pending 2 ★ Accident investigation	(Mon	th, Day Yeer)	Injury	Work	ເ?ື່ Yes 2.⊠X		Pedest viac			e, car
Atten r dea ector	LCa	3 ☐ Suicide 6 ☐ Could not b	28e. Place	of Injury - At h	ome, farm, st	reet, factory, office			28f. Location (St	reet and Nun		i Route Number,
s afte	9	4  Homicide	buildi	ng, etc. (Speci	"Stree	r		3	City or Town		ve, Bet	hesder, Mi)
	edical		niner: On the b			th occurred at the time evestigation, in my op						
To the within To the complex	ğ Z	29b. Signature and title of certifier		13		29c. License			2	9d. Date sign	ned (Month,	Day, Year)
15		> Za leill	ear	AC			CME			Janu	ary 21	l 2004 
		30. Name and address of person who ZMBILLEACT	AU			111 Pe		reet	, Balti	nore,	Maryla	end 21201
State Registra	-	31. Date filed (Month, Day, Year) JAN 22 20	04 32.	legistrar's Sign	ature &	Sporks						

			For State Registrar	State of	Marylan	-	artment <i>rtificate</i>			ind M	ental Hy	giene Reg. No	<b>ZUI</b>	) 4	038	3   3
			1. Decedent's Name (First, Middle, L	ast)						1	2. Date of De			·	3. Time of	Death
	Physicia		Nelson Way	ne Els	gin						Januar	ry I	5 2	004	1:00	АМ
E	/Medic Examin		4a. Fecility Name (If not institution, go				4b. City, 1	Town, or	Location of	f Death		4c	. County of	Deeth		
		•	Shady Grove Adv	entist N	ursing	Home	Roc	kvi]	.le			N	fontg	omer	у	
	Funeral			Sex	7. Age (in yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)		9. Birthpl	ace (State o	or Foreign
п	Director		217-32-0398	1 M 2 □ F	69	Yrs.	Wichting	Duyu			May 1,				ngton	
	D .		Usuel Residence of Decedent  10a, State 10b, County		10a Cit	y, Town or Lo	aatiaa							1/	Od. Inside Ci	ity Limite
	arylar show	_				•								, ,	1 ☐ Yes	
	Ba-f	cto	Maryland Montgor	nery	Wa	shingt						10 0				-10
	or 2	Directo	10e. Street and Number				10f. Zip						izen of Wh		•	
	be filed within 72 hours after death with the Marylan delivery with hygiene. A set of the than "natural", or liams 23a or 28a-1 show strent than "natural", or liams 23a or 28a-1 show swent. Its Medical Examilities as		12 Center Stree			2 10		0880		-:-2 (0	-# VN		ted S			
	er de	Funeral	11. Marital Status	Armed For		.5. 13.	vvas Deced If Yes, spec	fy Cuba	n, Mexican,	, Puerto I	cify Yes or N Rican, etc.)	0-		, White,		
9	rs aft	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes If Yes, Give Year or Da	9		1 ☐ Yes 2	∑ No	Specify:				Specify:	Wh	ite	
Ş	hou		15. Decedent's			16a. Dece	dent's Usua	I Occupa	ation			16b. K	ind of Bus			
Ş	in 72	olet	(Specify only highest g	rade completed)	45-)	(Give	kind of wor DO NOT us	k done d	luring most	of workii	ng					
2	iene.	Completed	Elementary/Secondary (0-12)	College (1:	-40r 5+)	Proba	ation	Off	icer			Sta	ate o	f Ma	ryland	d
0	Hyg other snt.	Be C	17. Father's Name (First, Middle, Las	st)					18. Mother	r's Name	(First, Middle					
<u>a</u>	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or litems 23a or 28a-f show marked other than "natural Examities maint be notilied at mainter and the notilied at	To B	Nelson C. Elgi	ln					At1	ee W	ayne W	irgm	an			
Maryland 21215-0036	shound M		19a. Informant's Name/Relationship		reonal	19b. Mailin	ng Address	(Street a			/ Route Numb			tate, Zip	Code)	
Ž	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked sny Injury or other traumatic st ones.		Earl C. Hill, J	r. /Rep.	IJOHAI	860 9	South	Rive	er Lai	nding	g Rd.	Edge	ewate	r, M	D 2103	37
Baltimore,	f Heal f Heal itsm		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of	e)		ate	20c. Lo	ocation - C	ity or To	wn, State	
e E	garago E in in in		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec			ropo1				Jan. 2004	10,	A1e	exand	ria.	Virg	inia
	orter	l ï	21. Signal re of uneral Service-Lic	-			2. Name and				Vol Fui				· 8	
Ba	Per Per Pur Sing	ð S	1 Lund	VI.						De	VOI Ful Gaitl				20877	
-1			23a. Pert1. Byter the disease, or co shock, or heart failure. List on	mplications that ca	used the deat										Approximat Interval Bet	
	Dhusisian		Immediate Cause (Final												Onset and I	
Age .	Physician   /Medical		disease or condition resulting in death)	_ w	Stage For as a conseq		ailur	e								
- 66	Examiner			Adva	nced Ca		opath	ıv								
		e	S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	or as a conseq		opati	.,								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
Ć,	exec n an	Exa	resulting in death) Last	Due to (	or as a conseq	uence of):										
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Ilcai		d												
89	tificat ng phy as th	ed														
ŏ	eath certifi attending for use as	an/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pre						23d. Date	of delive	ry	
m	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregna	ant at time of d		Other (spe						Mont	h	Day *	Year
Ö	that the de led by the a detached t	Physic	9 🗆 Unknown	9□ Unkno	own .						_					
ري ص	The law requires that the te has been signed by the age 2 should be detache	by P	Part II. Other significent conditions	contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco i	use contrib	uta to th	e cause of d	death?
ğ	w require been sig should b										1 🗆	Yes 2	<b>□</b> Mo 3	☐ Prob	abiy 4 □t	Jaknowa
Records,	s bee	olet									24a. Was		24b. W	ere autop	sy findings	available
R	The law te has age 2 s	Completed									auto perf	ormed?	de	ath?	npletion of c	ause or
Vita		0	25. Was case referred to medical	and Samuel View					26. Place	of Death	LiCheck only			2 103	20110	
	ysici s cer direc	To B	examiner? 1 ☐ Yes 2 ☐ NO	Hospital:	npatient 2	ER/Outpatier	nt 3 DO	A Othe	er: 4 amur	rsing Hor	ne 5 Res	idence	6 Other	(Specify	)	
0	g Phys er this eral di		27. Manner of Dwath	28a. Date o	of Injury h, Day Year)	28b. Time o	f 28	8c. Injury	at	2	28d. Describe	how inju	ry occurred	d		
0	Attending Physician: r death. sctor: After this certific. by the funeral director,	atio	1 ural 5 Pending 2 Accident investigat		ii, Day 16ai)	прогу	м		Yes 2□N	No						
Division of	Attendi er death. sctor: / by the fi	ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	of Injury - At h		eet, factory	, office		2	28f. Location	(Street ar	nd Number	or Rura	Route Num	ber,
	s afte	Cer		Janan	·9, o.o. (D)							,				
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying 1	Physician: To the aminer: On the ba	best of my kno	wledge, deat	h occurred a	at the tim	e, date and	d place, a	and due to the	cause(s	and man	ner as st	ated.	1)
	ths H in 24 ths F plete	ledical	one)	and mann							ar me mile					'
	with To 1	Σ	29b. Signature and title of certifier	6			290	. License	number			29d. Da	te signed (	(Month, I	Day, Year)	
	4		1 -26	1/20	2	inc	1	VID	57	177	17	0	11	5/	04	
			30. Name and address of person wh	0 .		n 23a) (Type,	Print) 8	60	721	J A	ve s	alver	nels	Mar.	MD	
		_ (	rialitar t	Civor, n			平	SVII	c 400	4 B				0 6	1001	0
	Sta Registr		31. Date filed (Month, Day, Year)	nna 32. R	egistrar's Signa	d d	100	eks	pa'							

			For State Registrer	State of Maryla	ind / Depa <i>Cei</i>	artment of H	lealth and M Death	ental Hygier	C U U 14	03814
			1. Decedent's Name (First, Middle, I					2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		ELAINE	PATRICIA	ELAM			JANUARY	18, 2004	9:50 P M
	Examin		4a. Facility Name (If not institution, g BROOKE GROVE REHA	AB. & NURSING		SANDY	SPRING		4c. County of Death	ERY
	Funeral Director		579 28 7901	Sex 7. Age (In yr. 1	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 27 1	er) 9. Birth Co.	place (State or Foreign intry) nington, D.C.
	land	1	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	Many f she	ţō	Md. Montg	omery	01ne <i>y</i>					1 □ Yes 2 ဩ(No
	h the	Director	10e. Street and Number			10f. Zip Code	-	10g.	Citizen of What Cou	intry?
	23a c	al	17837 Whimsey C	ourt		2083			Jnited Sta	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show amportant: if Item 27 is marked other then "natural", or Items 23a or 28a-f show amportant: injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ੴNo	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	in 72 hou natura Medical E	Completed by	15. Decedent's (Specify only highest)	grade completed)	16a. Dece (Give life.	dent's Usual Occupi kind of work done of DO NOT use retired	ation during most of worki	ng 16b	. Kind of Business/l	ndustry
212	d with giene. or ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 3	Hom	emaker			Own Home	
b	al Hyg	Be	17. Father's Name (First, Middle, La	st)				(First, Middle, Maid	•	
yla	Ment Ment Marke Marke	ဥ	Raymond Hart	T. Did	405 14570		Annabell	· - J		in On the
Mar	d 2 sh th and 7 Is n treun		James W. Elam /					<i>I Route Number, Cit</i> Iney, Mary	_	0832
<b>ē</b>	s 1 an   Heal  tem 2		20a. Method of Disposition		. Place of Dispo	•	! 0		Location - City or T	own, State
ē	Page nt: H		1 ☑ Burial 2 ☐ Cremation 3  3 4 ☐ Donation 5 ☐ Other (Spe		•	Cemetery	· .	1/04 Ge	ermantown	, Md.
Balti	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service Lic	ensee Barler	/ 22	Name and Address Muriel H	. Barber l	Funeral Ho _aytonsvil	ome lle, Md.	20882
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de ly one cause on each line.	eth. Do not ent					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	_ a.	Preun	6719				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
		Ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):					
Т	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events							
8760,	icate be executed physician and s the burial-transit	ai Exa	resulting in death) Last	Due to (or as a conse	equence of):					
687	ificate g phys as the	edicai		d		. 11				-
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etel death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	veny Day Year
	ires that the de signed by the a d be detached f	d by Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause give	an in Part I.	23e. Did tobacc	co use contribute to	
ecor	e law require has been si je 2 should b	Completed by						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
E E		Con						performed 1 ☐ Yes 2 ☐	? death? No 1 ☐ Yes	2 No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othi	26. Place of Death	The second second		
o to	Phye	2.10	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	☐ ER/Outpatier 28b. Time o	IT 3L DUA	nursing Hor	ne 5 Residence 28d. Describe how in		ify)
ion	Attending r death. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury		<br Yes 2 □ No			
Division of Vital Records,	l or Atter after des Director	Certification:	3 ☐ Suicide 6 ☐ Could no: 4 ☐ Homicide determine			reet, factory, office	-	28f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physicien: To the best of my k eminer: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my of	ne, date and place, a pinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	01/		29c. Licenso			Date signed (Month	Day, Year)
	2		) (Ald la	Mats Pl	74516147	D	0055694	J	970ary 1	9,2004
				MATHUR	em 23a) (Type, 4000		Leytonsol	ie Rd (	Black, Mi	26832
e)	Sta Registr	-	31. Date fited (Month, Day, Year)  JAN 2 0 2	32. Registrar's Sig	nature 6	Sporks	/			

		•	For Stele Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment of F rtificate of	lealth and I <i>Death</i>		iene •g. No	- C U U U	03815
ŀ	Dbi-i		Decedent's Name (First, Middle, Last	st)				2. Date of Dear Month			3. Time of Death
	Physici: /Medic	al -	LUDMILA		RENKOV			JAN.	22	, 2004	3:13 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, given Casey House	street and number)		Rockvi	r Location of Deatl	1	40	. County of Death Montgo	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday	ff Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vaar		place (State or Foreign ntry)
	Director		220-49-128/	□ M 2 🔀 32	Yrs.	Months Days	Hours Min.	Jan30	19	71 Kaz	akhstan
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits
	Maryl -f aho	tor	MD Montgo	omery	Saithe	ersburg					1⊠Yes 2 No
	or 28s	Director	10e. Street and Number			10f. Zip Code		1	0g. Ci	tizen of What Cou	intry?
	ath wi	raic	397 West Side			208			U	.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene death and other than "natural", or items 23a or 28a-f ahow event, the Medical Examinar matal be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2X No ff Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 🏖 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ameri Black, White, Specify:	
215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup e kind of work done	ation	400	16b. K	(ind of Business/Ir	
21	within 7 lene. then "r	Completed	(Specify only highest gra	Colfege (1-4or 5+)	life.	DO NOT use retire	dunity most of wor	KIIIG		hady Gr	
72	filed with Hygiene. other ther	Co	17. Father's Name (First, Middle, Last,	4	Phar	rmacist	18 Mother's Nar	ne (First, Middle,		V. Hosp	oital
au	ould be f Mental } arked of	To Be	Vladimir Ma				Galin			,	
Maryland	should be and Menta s marked umatic ev		19a. Informant's Name/Relationship (	Type, Print)		ing Address (Street	and Number or Ru	ıral Route Numbei	r, City	or Town, State, Zi	
	and 2 selth a n 27 ls		Veronika Federo			l6 Downi	ng St G				
Baltimore,	permit. Peges 1 and 2 should be Department of Heelth and Menta Important: If item 27 is marked any injury or other traumatic a DBG.		20a. Method of Disposition  12 Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	osition (Name of ematory or other pla				ocation - City or T	
Itin	artmer ortant injury		*4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			vn Mem.P					
ä	Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		Desige	K. Suouc	MIX:	246 N Wa	shingto	n St Ro	ck		•
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not en	nter the mode of dyin	ng, such as cardia	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	METASTA:	ric (	CARCINOM					Onset and Death 10 Mnths
	/Medical Examiner		Tesuting in coatry	Due to (or as a conse GASTRIC		NOCARCIN	OMA				10Mnths
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse							
	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last	c							
60,	ficate be executed physicien and s the burial-transit	al E	resouring in death, cast	Due to (or as a conse	quence of):						
68760,	ficate p phys	edicai	>	d							
ŏ	th cert ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnanc	ı			23d. Date of deliv	
P.O. Box	The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)				Month	Day Year
	res that the igned by be detact	/ Ph	Part II. Other significant conditions	contributing to death but not re	sutting in the	underlying cause giv	ren in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
rds	w requires been sign should be	ed by	Ovarian	Cyst				1 □ Y	es 2	<b>⊠</b> No 3□Pro	bably 4 Unknown
၀၁	lawre as bee 2 sho	Completed						24a. Was a autops	ın	24b. Were aut	opsy findings available ompletion of cause of
œ =	The cate his page	Com						perfor	med? 2⊠No	death?	2□ No
Zita Zita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only or			
o	Attending Physician: or death. ector: After this certifica by the funeral director, p	1: To	1 ☐ Yes 2 ☐ ★to  27. Manner of Death	28a. Date of fnjury	28b. Time	SIL 30 DOA	4   Nursing F	fome 5 Reside			(y) Hospice
ion	ath. r: Afte	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio		Injury		rk? Yes 2 □ No				
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined			treet, factory, office		28f. Location (S. City or Town		nd Number or Rur e)	al Route Number,
	spitaf ours a neraf E		29a. Certifier 1/X Certifying Pl	nysicien: To the best of my k	nowledge, dea	ith occurred at the ti	me, date and place	and due to the c	ausels	and manner as	stated
	n 24 h n 24 h he Fur	Medical	(Check only 2 Medical Executions)	miner: On the basis of exame and manner stated.	nation and/or i	nvestigation, in my	opinion, death occu	irred at the time, d	late an	d place, and due	to the cause(s)
	Vithi To th	Σ	29b. Signature and title of certifier	Libe		29c. Licens		2		ate signed (Month,	
•	10		P C :0				4/0		Τ/	22/2004	ł
			30. Name and address of person who Eugene P. Lib		om 23a) (Type 0 Con	necticut	Ave Ke	ensingto	on,	MD 208	385
	Sta		31. Date fifed (Month, Day, Year)	32. Registrar's Sig		1					
	Regist	rar	JAN 23 2	004 Deneva		Spark	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 03816 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Antonia January 4:15 P M Margaret Edwards 18, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 13906 Shannon Drive Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 10, 1913 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 F 031-10-3475 90 Montana Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛱 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13906 Shannon Drive 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anton Johnson Magdalen Gonsior 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13906 Shannon Drive, Silver Spring, MD 20904 Helen A. Edwards/ Daughter 20b. Place of Disposition (Name of Cemetery, cremetory or other place)
Arlington National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State February 18 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. |500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovarian Cancer 2 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 \$\mathbb{Z} \text{ Residence} 6 \text{ Other (Specify)} 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 January 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. A. Mendhiratta 2401 Research Blvd. #330, Rockville, MD 20850 31. Date filed (Month, Day, Year) JAN 22 2004

Registrar DHMH 17 Rev 1/2001

State

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hygiene.

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 ie marked other than

permit. Page Department of Important: If eny Injury or once.

**Physician** 

Examiner

/Medical

the attending physician and hed for use as the burial-transit

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Within 24 hours arren common To the Funeral Director: /

10

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Examinational Lauvalified at

souks

32. Registrar's Signature

Seneva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1 per me G829 3/11/04 tas

04	.34		Amend Item #1 per me G8 State of M	329 3/11/04 laryland / Depa	tas artment of Health a	and Menta	l Hygien	e 2001	00017
			1 - For Amend Item#1 Registrar Unpend Item#23a, PartII,				Reg. No	. 2004	3. Time of Death
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Reginald Reginald Devone	l Devone Edge, II Reg	ge II <del>ginald Edge</del>	Mo		5, 2004	2316 P M
Ž.	Examin		4a. Facility Name (If not institution, give street and number) EASTON MEMORIAL HOSPITAL	)	4b. City, Town, or Location of EASTON	of Death		: County of Death TALBOT	
	Funeral Director		230-53-4698 <sup>1⊠M 2□F</sup>	ge (In yrs. last birthday) 18 Yrs.	If Under 1 Year If Under Months Days Hours	Min (Mc	e of Birth onth, Day, Year, ot, 18,	9. Birthp Cour	olece (State or Foreign otry) VA
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	hours after death with the Maryland tural', or Items 23a or 28e-f show al Examinat must be rediffed at	Director	VA Prince William	Manassas	<b>3</b>				1 ☐ Yes 2 🛣 No
	with the or 2	Dire	10e. Street and Number 8402 Aubrey Drive		10f. Zip Code 20111			itizen of What Cour USA	ntry?
	death ms 23	Funeral	11. Marital Status  12. Was Decedent Armed Forces?	t Ever in U.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	gin? (Specify Ye		14. Race - Americ	
9	s after , or Ite	by Fu	1 Never Married 2 Married 1 ☐ Yes 2 Narried If Yes, Give	] No	1 Yes 2 No Specify:		etc.)	Black, White,  Specify: B1a	
2-0036		ted b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. k	(ind of Business/Ind	dustry
Z	within 72 iene. than "nai	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	lite.	kind of work done during mos DO NOT use retired)	t of working			
N	e filed will Hygien other th		5 17. Father's Name (First, Middle, Last)		Student	er's Name (First,		cial Need	s School
yland	0 = 0 5	To Be	Reginald Devone Edge			i Noreer		The state of the s	
Mar	d 2 shoth and the modern treum		19a. Informant's Name/Relationship (Type, Print)  Reginald D. Edge, Father		ng Address (Street and Number 2 Aubrey Drive		-		(Code)
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	esition (Name of matory or other place)	Date	-	ocation - City or To	own, State
Ē	Pages nent of ent: If it		Donation 5 ☐ Other (Specify)	3		1-22-200	)4 Tri	ngle, Va.	22172
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Importent: If item 27 le marked any injury, or other treumetic e once.		21. Signature of Funeral Service Licensee  Bornard O, Ama	22	2. Name and Address of Facilit Ames Funeral 1 8914 Quarry Ro	Home, In		a. 20110	
J			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not ent line.					Approximate Interval Between Onset and Death
. 1	Physician /Medical		resulting in death)	ronchopneumoni	a				Oliset and Death
	Examiner			s a consequence of):					
	P #	iner	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of					<u> </u>
	xecute and	Examiner	that initiated events	s a consequence of):					
2/60	death certificate be executed e attending physician and id for use as the burial-transit	ical	d.						
٥	leath certifica attending ph I for use as th		IF FEMALE:	a of programm					
ROX	death c	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 23c. If yes, outcome 1 ☐ Live birth 4☐ Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)		34	23d. Date of delive Month	Day Year
J.	at the c by the	hysi	9 Unknown						
ecords, I	requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death to Seizure Disorder due to Sotos Syn	but not resulting in the united in the unite	nderlying cause given in Part I.	. 23	e. Did tobacco 1 ☐ Yes 2	use contribute to th	ne cause of death? ably 4 Unknown
eco	e law re has bee	ompieted				24	a. Was an autopsy performed?	24b. Were autoprior to cordeath?	psy findings available mpletion of cause of
VIIal	sician: The law certificate has i irector, page 2 s	e Co	25. Was case referred to medical		26 Blace	of Death (Chec	Yes 2□No	1 DYYes	2□ No
	<u>&gt;</u>	To B	examiner? 1 XYes 2 No Hospital: 1 ☐ Inpati	ient 2 ER/Outpatien	Other			6 ☐Other (Specify	<i>'</i> )
lon or	m 0 0		27. Manner of Death  1 ĀNaturał  2 ☐ Accident  28a. Date of Inju (Month, Da	ury 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ I		scribe how inju	ry occurred	
DIVISION	ol or Atte i after de: I Directo d in by th	ertification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of In building, e	njury - At home, farm, str stc. (Specify)	eet, factory, office		ation (Street ar or Town, State	nd Number or Rura e)	l Route Number,
	To the Hospitel or Attendin, within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best care and manner st	of examination and/or in:	n occurred at the time, date an vestigation, in my opinion, dea	d place, and due th occurred at th	to the cause(s e time, date and	) and manner as st d place, and due to	ated. the cause(s)
	within To the compl	Me	29b. Signature and title of certifier		29c. License number		29d. Da	ite signed (Month, I	Day, Year)
	3		Jaska Poe	mbery M	OCME		JAN	UARY 16,	, 2004
			30. Name and address of person what impleted cause of a Tasha Z Greenberg M.D.			1+2			
1	Sta	te	31. Date filed (Month, Day, Year) 32. Registr	trar's Signature	Sparks	Trimore	, Maryl	and 21201	
	Registr	ar	JAN 2 0 2004 A	wa B	ppours				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6, 2004 Month **Physician** JESSE JAMES ENGLISH 1250 M JANUary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 cours 2526 Freson Temple Hills Street If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** October 12,1941 103-34-3891 62 Yrs. Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. In the Inportent: if item 27 is marked other than "naturel", or items 23a or 28a-f show emprortent: if item 27 is marked other than "naturel", or items 23a or 28a-f show emprisher or other traumatic avent, the Medical Exemplest must be notified at once. 1 XYes 2 No MD Prince George's Hillcrest Director 10f Zin Code 10g. Citizen of What Country? 10e, Street and Number 20748 USA 2526 Iverson Street Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marltal Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry New York City Police Elementary/Secondary (0-12) College (1-4or 5+) Dept. Policeman 1.2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Jesse James Jones Minnie R. English 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Madison Street #4D New York, NY 10002 Contessa Simmons/Friend 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2004 Riverdale, MD Riverdale Park Crematory 21. Signature of Figneral Service Licens 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Attacos clarati CANdioVAS ENON HEART **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours after To the Funeral Dire To the Hospital 1 Cenifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) London 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOS 31. Date filed (Month, Day, Year) 🔐. Registrar's Signature State JAN 2 2 2004 Registrar

		1 = For Unpend Item 23a Registrar		Certific	ate of Death		Reg. No.	~ ~ ~ ;	0001
Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Yeer	3. Time of Death
/Media		Jeffrey Rica			. T	Janua		2004	1158 A.
Examir	er	4a. Fecility Name (If not institution, give			ity, Town, or Location of De			nty of Death	
		8231 - 14th Avenue  5. Social Security Number 6. Se			Hyattsvil  der 1 Year   If Under 24 H	rs. 8. Date of Bir	th		eorge 's place (State or Fore
uneral rector		10	M 2□F	39 Yrs. Mont			y, Year)	Coul	ntry)
rector		219-94-4207 Usuel Residence of Decedent		.39		Aug. 27	1,504	Was	sh., DC
MON W		10a. State 10b. County	10c. Ci	ity, Town or Location				1	Od. Inside City Lim
1	ctor	Maryland Prince	George's	Hya	ttsville				1 X Yes 2 □
or 28	Director	10e. Street and Number	J		Zip Code		10g. Citizen o	of What Cour	ntry?
23a		8231 - 14th Ave			20783			ted S	
E E	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was De lf Yes,	ecedent of Hispanic Origin? Specify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. R	ace - Ameni lack, White,	an Indian, Pean
lo I	by Fi	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:	1 🗆 Ye	s 2∏ No <i>Specify</i> :		ı	city: Ame	
le Ex	d be	15. Decedent's Edu		16a. Decedent's I	Isual Occupation		16b. Kind of		
an June	Siet	(Specify only highest grad	e completed)	(Give kind o	work done during most of v T use retired)	vorking			,
the state	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Student			1	None
ent,	a	17. Father's Name (First, Middle, Last)				ame (First, Middle,	Maiden Sum	-	10110
r le marked other then ". raumatic event, the Mes	ToB	James Louis	Eubanks, Jr.			Eunic	e Bray		
umat	-	19a. Informant's Name/Relationship (Ty		19b. Mailing Add	ess (Street and Number or	Rural Route Numbe	er. City or Tow	m, State, Zip	Code)
27 le r tra		James L. Eubanks,	JrFather	1013 We	est Nolcrest	Dr., Silv	er Spr	ing, 1	1D 2090
item othe		20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	Name of or other prepark	Date	20c. Location	n - City or To	own, State
nt: If		1 ♣ Burial 2 ☐ Cremation 3 ☐ F  1 ♣ Donation 5 ☐ Other (Specify)	ellioval Itolii State		onal Mem. 2/	2/2004	Lau	rel. N	AD.
Important: If item 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examination at once. 2000s.		21. Signature of Funeral Service Licens			and Address of Facility	Stewart			
eny ii		I John T. S	Leway 11		001 Benning	Rd., N.E.	Wash.	, DC 2	20019
- A-3		23a. Part 1 Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea	th. Do not enter the	node of dying, such as card	iac or respiratory a	rrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Acute Bronch	opneumonia				- 4	Onset and Death
edical		resulting in death)	Due to (or as a conse	-					
miner		Sequentially list conditions,	),						
######################################	ner	if any, leading to immediate cause. Enter Undertying	Due to (or as a conse	quence of):					
physician and is the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	)						
cian a		1030tting in douth) cast	Due to (or as a consec	quence or):					
ng physicia as the bu	lica		d						
	by Physician/Medica	IF FEMALE:	3c. If yes, outcome of pregn	anov		<del></del>			
attendin for use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3 □Ectop	c pregnancy			Date of delive Jonth	ery Day Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5 ☐ Other	(specify)				
ed by the atted	Ph	Part II. Other significent conditions con	ntributing to death but not re-	sulting in the underlyi	ng cause given in Part I.	23e. Did t	obacco use co	ontribute to the	he cause of death?
De g						10	Yes 2. 1 No	3 🗆 Prob	ably 4 Unkno
pluods	Completed					240 1460	3	More evite	findings quali
page 2 s	id II					24a. Was autor		prior to co death?	psy findings availa mpletion of cause
cate						1 X Yes	2 No		2□ No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only o			
s E	2	1  Yes 2 No 27. Manner of Death	1 Unpatient 2L	ER/Outpatient 3  28b. Time of	DOA 4 INDISING	Home 5 Resident			y)
를 를	lo.	1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 2000/120 /	now inquity out		
After thi funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h			28f. Location (	Street and Nu	mber or Rura	Al Route Number,
ctor: After this of the funeral dir	ertii	4 ☐ Homicide determined	building, etc. (Spec	ify)	,	City or Tox			
Director: After thi	(5)	29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my kn	lowledge, death occur	red at the time, date and pla	ce, and due to the	cause(s) and	manner as s	tated.
isrel Director: After thi filled in by the funeral		(Check only 2 Medical Exami	ner: On the basis of examin	ation and/or investiga	tion, in my opinion, death oc	curred at the time,	date and place	e, and due to	the cause(s)
Funerel Director stely filled in by the		one)	and manner stated.			——————————————————————————————————————	29d. Date sign		
Funerel Director stely filled in by the	Medical (	29b. Signature and title of certifier	and manner stated.		29c. License number		23d. Date sign	nea (Monin,	Day, Year)
To the Funarel Director: After thi completely filled in by the funeral or	edicai	one)	and manner stated.	10	29c. License number O.C.M.E.		_	ry 21,	
Funerel Director stely filled in by the	edicai	one)	echera	om 23a) (Type Print)	O.C.M.E.		Janua	ry 21.	2004

ORIGINAL

			. For	State of Marylan		artmer	t of H		and Me	ental Hyg	jiene	2001	03820
			1 - State Registrar		Ce	rtificat	e of L	Death			Reg. No.	2009	00020
ı	Physici		1. Decedent's Name (First, Middle, Last)	Foster						2. Date of Dea Month	Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City.	Town, or	Location o	of Death		4c.	County of Dea	th
			Shady Grove Adventi	st Hospital		1	Rockv					ontgome	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2121 F	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	y, Year)	Co	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	07	****				] \	Jan. 21	, 19	to was	hington, D.C.
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	e Maria	ctor	Maryland Montgomer	у	Derwoo	d							1 T Yes 2 No
	or 28	Director	10e. Street and Number	1		10f. Zip		FE				zen of What Co	
	s 23a	eral	16608 Briardale Ro	ad  . Was Decedent Ever in U	S 13	Was Dece	208		nin? (Snec	ify Yes or No-		ted Sta	
	ter de	Funeral	11. Marital Status  1  Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No					Puerto P	cify Yes or No- lican, etc.)		Black, Whit	
99	al', o	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2/ <sub>2</sub> No	Specify:				Specify: [	Mite
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or llame 23a or 28a-f show yellosi Examiner must be mellied at	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece (Give	kind of wo	ork done d	uring most	of workin	g	16b. Ki	nd of Business	/Industry
121	within ane. than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen	<i>DO NOT L</i> naker	se retired)				Ow	n Home	
<b>d</b> 2	Hygir other ent,	Be Co	17. Father's Name (First, Middle, Last)		120111011			18. Mothe	r's Name	(First, Middle,			
ian	Aenta Aenta rked tlc ev	To B	Wilhelm Schmidt					Johan	nna L	eiding			
lary	2 sho and h is ma		19a. Informant's Name/Relationship (Type		14	-						r Town, State,	
2 ⊚	l and lealth im 27 her tr		Joanne B. Ward/Niec		610 C			m Roa	id, Ve			Florida cation - City or	a 32963 Town State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28a-f show many intry or other traumatic event, the Modical Examiner must be notified at once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	emetery, cre	matory or	other place	. 10	anua	ry 22,			Maryland
Ħ	artme artme injury		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		tgomery				200	uneral			esda-Chevy
Ba	Depar Impor any ir	/ ()	Ration	M001	98 75	obert 57 Wis	A. E scons	'umph: in Av	rey E e. B	uneral ethesda	Hon MD	ne/ c 20814-	hase. Inc.
-6	7.0		23a. Part1. Enter the disease, or complications, or heart failure. List only one	ations that caused the deat cause on each line.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Urosec	15:5	(F	Sche	OFIC	4:4	(cli)			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	1 4	-1			,			1045
		J.	Sequentially list conditions, b.	Due to (or as a conseq	uence of):	9()	911	VC6					9493
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
ó	ate be executed sysician and he burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):								
3760,	ate be hysicii ihe bu	Ilcal	d.										
x 68	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23	c. If yes, outcome of pregna	ancv							23d. Date of de	liven
Вох	eath certifi attending   I for use as	cian	in the past 12 pronths?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	□Ectopic p □ Other (s						Month	Day Year
P.O.	that the death led by the atter detached for i	hysi	1 Yes 2 No 9 Unknown	9□ Unknown									_
	res tha igned l be det	by P	Part II. Other significant conditions control	ta fi e	- (	underlying	cause give	n in Part I.				/	o the cause of death?
ord	v requir been si should	ted	venenty	Alsheim						1 🗆 Y	θ\$ <b>2</b>		robably 4 Unknown
Records,	e law has b	Completed by	High Blood	rressure						24a. Was a autop: perfor	SV	24b. Were a prior to death?	utopsy findings available completion of cause of
			145thm9					00 81	-4 045	1 Yes	2000	1 Yes	2 2 10
Vital	ysician: The is certificate ha	To Be	25. Was case referred to medical examiner?  1 Yes 2 Yo	spital:	ER/Outpatie	nt 3□ D	OA Othe	AF.		(Check only or e 5 ☐ Resid		6 ∐Other (Spe	ecify)
J Of	는 등 등		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injury Work	at		8d. Describe h			
Sior	endin eath. or: Af the fur	catlo	2 Accident investigation			М		res 2□l					
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specil		treet, factor	y, office		2	8f. Location (S City or Tow	n, State	d Number of H )	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			cian: To the best of my kno									
	n 24 h	edical	(Check only 2 Medicel Examine one)	er: On the basis of examina and manner stated.	ation and/or in	nvestigation	n, în my op	pinion, deal	th occurre	d at the time, d	date and	place, and due	e to the cause(s)
	withi To t	Σ	29b. Signature and title of certifie	2 -2/4. MI			c. License		09		-	e signed (Mont	
•	12		· CM V	100 m			レフ	72	7 1		19	nuor	1 17,2009
	, -		30. Name and address of person who con	npleted cause of death (Iter	A	A IC	a) (	ente	0	rive	Ro	nuor	le, MD
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	+			1					
	Regist	ar	IAN 22 200	4 Seneva	N	M	vers						

			1 - For State Registrar AMEND#29 coerM	State of Ma		Depa	rtment of H	ealth and N Death		iene g. No. 20	04	03821
15	STORY TO	15	1. Decedent's Name (First, Middle, La		<u></u>	007	imodio or E	Journ	2. Date of Deat	n		3. Time of Death
	Physici		Frank Joseph	Formeller					January		Year 04	4:34 p M
9	/Medic		4a. Facility Name (If not institution, giv				4b. City, Town, or	Location of Death		4c. County of		
			Montgomery Hospic	e- Casey H	ouse		Rockvil			Montg		
	Funeral Director		5. Social Security Number 6. S 342-24-0483	Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 21,	<sup>Year)</sup> 1930	9. Birthpla Count I11i	ace (State or Foreign ry) nois
	pu ,		Usual Residence of Decedent		10c. City, To	oum or Lo	nation				10	d. Inside City Limits
	shov	7	10a. State 10b. County								10	1 ☐ Yes 2 ⊠ No
Z.15-UU36 Thin 72 hours after death with the Maryland B B B B B B B B B B B B B B B B B B B	28a-f	Director	Maryland Montgo:	mery	<u>S1</u>	lver	Spring 10f. Zip Code		10	og. Citizen of W	hat Count	iry?
	3a or		14217 Georgia Av	enue, Apt.	T-1		20906			USA		
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race	- America	
	rs after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 XYes 2 No If Yes, Give Year or Dates: 1			☐ Yes 2 ☑ No	Specify:	· · · · · · · · · · · · · · · · · · ·		Whi	
9500-61212	2 hou	ted	15. Decedent's E	ducation		6a. Deced	ent's Usual Occupa	ation	S. 11	16b. Kind of Bus	iness/Ind	ustry
2	within 72 ene. than "na' be Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5-	+)	(Give	kind of work done d OO NOT use retired,	luring most of work )	ang			
	filed wit Hygiene other the	Соп		5+		Phy	siologist			U.S.		
yiand	uld be filed within fental Hygiene. rked other than tic event, the We	Be	17. Father's Name (First, Middle, Last						e (First, Middle, M		)	
	es 1 and 2 should be of Health and Mental fitem 27 is marked or rother traumatic even	ဥ	Florian J.	Formeller		Oh Mailin	g Address (Street a		McGuire		tota Zin (	Cada
Z Z	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (							•		
d)	Heall Heall tem 2		John J. Formeller 20a. Method of Disposition	./ 5011	20b. Place	of Dispos	Partrid			20c. Location - 0		
Baitimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special			ngtor	natory or other place n Nationa	1 Febru	1ary 3 2004	Arlingt	on	Virginia
	mit. Foortand		21. Signature of Funeral Service Lice		1	22	metery Name and Addres	s of Facility				VIIgInia
ñ	F F F 8	1. 1	dames	2 Dock	7	50	ancis J. 0 Univer	sity Blv	runeral 1. W., Si	llver Sr	ring	, MD 20901
			23a. Pert1. Inter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. E	o not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Mesothel	Lioma							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):						
		<u>.</u>	Sequentially list conditions,	b. Due to for as a	consequen	ce of						
	red nsit	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury			2007						
,	n and ial-tra	Exai	that initiated events resulting in death) Last	c. Due to (or as a	consequen	ce of):						
8/60,	cate be executed physician and the burial-transit	dical		_ d								
9		a a	IF FEMALE:							-	80 50	
X Q Q	death certifi e attending p d for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	2 ☐ Fetal dea	ath 3 🗌	Ectopic pregnancy			23d. Date Mont		y Day Year
o.	at the dea by the ai tached fo	/sicl	1 Yes 2 No	4∏Pregnant at t 9☐Unknown	time of death	5 🗆	Other (specify)	<del></del>		13		
7	that the side by detac		Part II. Other significant conditions of	contributing to death bu	t not resultin	g in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contrit	oute to the	cause of death?
Vital Records,	The law requires that ite has been signed b page 2 should be deta	d by				-	_		1 ☐ Yes	s 2. <b>∑X</b> No <b>-</b> 4	E Proba	bly⊷. 4 ⊟Unknown
Ö	w requires been si should I	Completed							24a. Was an	24b. W	ere autop:	sy findings available
ž	The law	dwo							autopsy perform		ior to com ath? ] Yes 2	pletion of cause of
<u>ta</u>		0	25. Was case referred to medical					26. Place of Deat	h (Check only one			
	dis dis	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatien	nt 2 ER/	Outpatien	3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Resider	nce 6 ⊠Other	(Specify)	Hospice
n of			27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28t	b. Time of Injury	28c. Injury Work		28d. Describe how	w injury occurre	d	
SIO	tend death tor: the	icati	2 Accident investigatio 3 Suicide 6 Could not b		n. Athama	form star		res 2 □ No	28f. Location (Str.	not and Alumba	or Pural	Route Number
Division	pital or Atten ours after deat ieral Dirsctor: filled in by the	Certification:	4 Homicide determined		ry - At nome, . (Specify)	, rarm, stre	et, ractory, onice		City or Town,		or nurar	noute (vultiber,
	e Hospital or Al 124 hours atter of 8 Funeral Directer of the Birecter of the			nysician: To the best of miner: On the basis of								
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in D	Medical	one) 29b. Signature and title of certifier	and manner stat	led.		29c. License			d. Date signed		
•			> KA		M	9	D3563	35		January	20	2004
15	541		30. Name and address of person who	completed cause of de	ath (Item 23	a) (Type, I				January	۷٠,	
_							Mill Road	d, Rockvi	lle, MD	20855		
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 22 20	32. Registral	r's Signature	B	Sports	,				

			1 - For State Registrar		State	of Ma	ryland	d / Depa <i>Ce</i>	artmer <i>rtificat</i>	nt of H e of t	ealth a D <i>eath</i>	and M	ental Hy	ygien Reg. N		004	0382	22
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Thysing Foots Thysing Foots									A Xeer	3. Time of Death	1				
	/Medic	al	5 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									1:20 A	М					
1	Examin	er	4a. Fecility Name (If not instit Tarking	con		umber)					Location					of Deeth		
		-	3603 Parking  5. Social Security Number	Lane <sub>Bex</sub>	7 Age	(In vrs la	ast birthday)			prin If Under		8. Date of B		ontgo	omery	olace (State or Fore		
L	Funeral Director		297-09-8506	<b>X</b> M 2□ F	go	84	Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Yea		Cou	ntry)	ign	
	ש		Usuef Residence of Deceden	1									May 29	7, 1	919	Ohio		
rylan	rylan how		10a. State 10b. County 10c. City, Town or Location									10d. Inside City Lim	its					
	e Ma	cto	Maryland Montgomery Silver Spring										M∏Yes 2□I	No				
ë E	or 28	Dire	10e. Street and Number Tarkington 10f. Zip Code 10g. Citizen of Wha									What Cou	ntry?					
	ath w	rai	3603 Parkington Lane							906				USA				
	er de	une	11, Marital Status		12. Was De Armed F	orces?		5. 13.	Was Decedif Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe	cify Yes or N Rican, etc.)	0-		ce - Americk, White,	can Indian, etc.	
36 saff	', or	by Funeral Director	1 ☐ Never Married 2 ☐ X 3 ☐ Widowed 4 ☐ Divor		If Yes, G Year or	2 □ No live	`WWI]	с	1 □ Yes	2 No	Specify:				Specify	Whi	te	
8	within 72 hours after death with the Maryland ene. than "natural", or itams 23s or 28s-f show he Madical Examinatorius be notified at	ed t	15. Dece		l	Dates.		16a. Dece	dent's liku	al Occupa	ition			16h		usiness/In		
15	n n n	plet	(Specify only hi	ghest gra	de completed	(1.45		(Give	kind of wo	rk done a	urina mos	t of workii	ng	100.	King of B	usii iass/ii	dustry	
21215-0036	d with	Completed	Elementary/Secondary (0-1	2)	5+ <sup>College</sup>	(1-401 3+	'	Manag	ement	: Ana	lyst			U	J.S.	Navy		
פ	othe othe	Be C	17. Father's Name (First, Mid	dle, Last	)								(First, Middle	. Maide	n Suman	ne)		
Baltimore, Maryland	Ments Ments arked artic e	ToE	Earl Foote								Dorot	thy E	udde					
	2 sho and is mu		19a. Informant's Name/Relat	onship (	Type, Print)			1	Tark	ידממני	On .		Route Numb					
	and ealth m 27		Iverna Foote-	Spo	use			The second second	<del>rarr</del>	<del>ling t</del>	<del>on</del> • La		ilver	Spr	ing,	MD 2	0906	
	Hite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3 🗆	Removal from	State	20b. Pla	ace of Dispo metery, crei don Pa	sition (Nai	ne of ther place	9)	D 11/20	ate / 2.0.0.4			City or To		
	tant:		` 4 □ Donation 5 □ Othe	r (Specif	y)		Louc									ore,		
Ba	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f show ery injury or other traumatic event, the Medical Examinational Legical at 900.		21. Signatur of Funeral Sen	ice Licer	U.L	,							s-Rina Ave. S				Home , MD 2090	th M eign nits I No
6.8			23a. Pert1. Enter the disease shock, or heart failure.	, or com	plications that one cause on	caused the	he death.	. Do not ent	er the mod	e of dying	, such as	cardiac o	respiratory a	arrest,			Approximate Interval Between	
F	Pnysician		Immediate Cause (Final disease or condition					liac D	eath							I	Onset and Death mmediatel	Ly
	/Medical		resulting in death)		Due to	(or as a	conseque	ence of):										_
	Examiner		Sequentially list conditions,	-	D			diomy	opath	y-Is	chemi	LC				7	Years	
	sit ad	ine	day leading to inmediate cause. Enter Underlying Cause (Disease or injury	1			nonseque											
_	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last		C		conseque	ibros	18								Years	
58760,	be e ician buria	a E		ı		(0, 00 0	00,10040	31,00 31).										
587	phys s the	dicai			_ d									_		-		
×	death certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	Ш	23c. If yes, ou	itcome of	pregnan	су							22d Day	to of dolling		
Box	atter of for u	Physician/M	in the past 12 months?	ĺ	1□Live	birth 2	Fetel of dea	death 3 □	Ectopic pr				23d. Date of deliver Month				Day Year	
P.O.	the c by the achec	hysi	9 Unknown		9□ Unkr	nown					_							
	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a:	by P	Part II. Other significant con-	ditions o	ontributing to	death but	not resul	ting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco	use conti	ribute to th	ne cause of death?	
Records,	w require been sig should b	edt	Type II Diabe	tes	Mellitu	ıs wi	th N	Teurop	athy				1 🗆	Yes 2	⊠No	3 🔲 Prob	ably 4 DUnknov	VΠ
ပ္ပ	aw re	Completed	Chronic Renal	Fai	lure								24a. Was		24b. V	Vere auto	psy findings availab	ole
	The law	E O											auto perfo	ormed?		prior to condeath?	npletion of cause o	f
IIa	Physician: Th this certificate ral director, pag	BeC	25. Was case referred to med examiner?	lical							26. Place	of Death	(Check only	2X No one)	,	103	2X 110	
<u>&gt;</u>	sir di	2	1 ☐ Yes 2 ☐ No		Hospital: 1 🗆	Inpatient	2□€	R/Outpatien	t 3 DC	A Othe	r: 4 □ Nu	rsing Hor	e <b>X</b> □ Resi	dence	6 Oth	er (Specify	1)	
<u> </u>	ding Ph h. After th funeral	on:	27. Manner of Death 1 □Natural 5 □ Per	ndina	28a. Date (Mor	of Injury	Year) 2	28b. Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe	how inju	ıry occurr	ed		
<u> </u>	tendi leath, lor: A the fu	cati	2 Accident inv	stigation					М		es 2 🗆 1	Vo						
Division of Vital	or At	Certification:		emined	28e. Pfac build	e of Injury ling, etc.	y - At horn (Specify)	ne, farm, str	et, factory	, office		2		tion (Street and Number or Rural Route Number, or Town, State)				
	pital ours a erai i filled		29a Certifier 1 XCerti	hina Dh	veicies. To the	o bost =/	emu ter -	lodes deed		na ak		1.1					7.0	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medi	cal Exam	ysician: To the trainer: On the trainer	e best of e pasis of e oner state	xamınatıd	neage, death on and/or inv	occurred restigation,	at the time in my op	e, date and inion, deat	piace, a h occurre	nd due to the d at the time,	cause(s date an	) and ma d place, a	nner as st and due to	ated. the cause(s)	
	o the	Me	29b. Signature and title of cer	ifier.	and mar				290	License	number			29d. Da	ite signer	(Month.	Day, Year)	
1	10		Pilde	m	Uma	is				3045					_		2004	
	Į v		30. Name and address of pers	on who	completed cau	se of dea	th (Item :	23a) (Tvna	Print)									
			P. Henjum, M.							ney,	MD 2	0832						
4	Sta Registra		31. Date filed (Month, Day, Ye JAN 2	ar)	32. F		s Signatu		1	aks								

			1 - For State Registrar	State of Maryla		artment of F			iene g. No. 20 (	04 03823			
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death			
	Physici /Medio		Lyle C. Farmer					January		<sup>9аг</sup> 4 10:00 Рм			
*	Examin		4a. Fecility Name (If not institution, give str			4b. City, Town, o	r Location of Dea		4c. County of				
			Rennaissance Gardens	at Riderwood V	/illage	Silve	r Spring	2	Montgo	mery			
	Funeral		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year			9	Birthplace (State or Foreign			
	Director		304-28-7425	<sup>M 2□F</sup> 89	Yrs.	Months Days	Hours Min	Nov. 4.		North Dakota			
	p.		Usual Residence of Decedent										
	aryla		10a. State 10b. County	10e. C	ity, Town or Lo	cation				10d. Inside City Limits			
	Ba-f	cto	Maryland Montgome	ry	Silve	r Spring				1 ☐ Yes 2 反 No			
	or 2	Director	10e. Street and Number			10f. Zip Code		10	ng. Citizen of Wha	it Country?			
	ath v	<u>a</u>	3610 Gracefield Ro			20	904		US	A			
	er de	Funerai		. Was Decedent Ever in t Armed Forces?	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	lispanic Origin? (	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.			
36	s afte	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify: [				
Ş	hour	D D		Year or Dates: 194									
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow ha Medical Exami as runal be indilled at	Completed	15. Decedent's Educa (Specify only highest grade of		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b. Kind of Busin	ess/Industry			
12	withi ene. than	E	Elementary/Secondary (0-12)	College (1-4or 5+)				T 1	E . 1 1				
9	filed Hygi other	ŭ	17. Father's Name (First, Middle, Last)	5+	Auli	inistrat		me (First, Middle, N		Government			
an	d be antai	To Be	John Farme	r									
Maryland	shoul od Ma mari	1	19a. Informant's Name/Relationship (Type		19b Mailin	a Address (Street		ouise McC		to Zin Codel			
	od 2 strau												
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment if the Z1 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examples invalined at Once.		Lyle Michael Farmer 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		ve Kensi	ncton 1 Oc. Location - City				
<u></u>			1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren	novariiom State	-	natory or other plac	i ⊔Jar	nuary 19					
Baltimore,	it P intme inten		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licensee</li> </ul>	Me		tan Crema	tory	2004	Alexandr	ia, Virginia			
Ba	Department Department Impo		21. Signature of Pulleral Service Eleansee	0	Fr	ancis J.	Collins	Funeral 1	Home Inc	•			
			23a Part 1 Enter the disease or complian	tions that source to doe	50	U Univers	sity Blv	d. W., Si	lver Spr	ing. MD 20901			
			23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final)										
	Physician	n i	Immediate Cause (Final disease or condition resulting in death)	Urosepsis						Days			
	/Medical Examiner		Tooling in double	Due to (or as a consec	quence of):								
	<u> </u>	_	Sequentially list conditions, b.	Due to (or as a consec									
	ped Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Causes or ir jury that initiated events	Due to (or as a consec	quence or):					re-			
	and and Il-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a consec	nence of):								
8760,	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	al E			400.100 0.7.								
387	phys the	dical	d										
9 x	leath certific attending p	/Me	IF FEMALE: 23c	. If yes, outcome of pregn	ancv								
Вох	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year			
O.	that the ded by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	10atii 5	Other (specify)							
۵.	that the ed by detac	무	Part II. Other significant conditions contri	buting to death but not res	sulting in the un	derlying cause give	en in Part I	23e. Did toba	acco use contribut	e to the cause of death?			
Records,	uires sign d be	d by	Macroglobulinemia						s 2 🖾 No 3 🗆 Probably 4 🗀 Unknown				
Ö	w requir been si should t	ete	- Including						TE 165 ZENO SET TODADIY 4 ECHANOWI				
ğ	has has	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of			
										/es 2□ No			
Vita	Attanding Physician: r death. ector: After this certific. by the funeral director.	Be	25. Was case referred to medical examiner?	pital:		Othe		ath (Check only one					
ō	Phys this ral dii	5	1 162 5 2 140	Pital. 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient		4 XI Nursing F	lome 5 Residen		Specify)			
5	ding h. After funer	io	1 Matural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	vinjury occurred				
2	ttandi death. ctor: A y the fu	ica	2 Accident investigation 3 Suicide 6 Could not be	20.0 Diago of Injury. At h	000 0 40		/es 2 □ No	2011					
Division of	i i i i e	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	(y)	et, factory, office		City or Town,	et and Number or State)	Rural Route Number,			
_	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1⊠ Certifying Physici	ian: To the best of my kno	wladge death	nonurrad at the t	o date and at-	l and die is					
	Hos 24 h Fun etely	Medicai	(Check only 2 Medical Examiner one)	: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	e, date and place inion, death occu	e, and due to the cau arred at the time, dat	ise(s) and mannei e and place, and c	as stated. due to the cause(s)			
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier			29c. License	number	200	d. Date signed (Me	onth Day Year			
	r s F o		//ala	act ms				230	(M)	,, , , , , , , , , , , , , , , ,			
V	241	-	30 Name and address of name who	plotted causes of death "	n 22a) (f	D34.	590		January	19, 2004			
_			30. Name and address of person who comp Dr. Roy Fried 311					WD 00055					
	Sta	e	31. Date filed (Month, Day, Year)	.0 Gracefiel  32. Registrar's Signa	u KOad,	Sliver	spring,	ми 20906					
	Registra	-	JAN 2 0 2004		19	Sporks							

	•	For State Registrar	State of Marylan		tificate of		-	Reg. No 2004	03824
ysicia		1. Decedent's Name (First, Middle, Las	1)			7	2. Date of De Month	eath Day Year	3. Time of Death
Medic		Pearl Ford						y 14, 2004	3;15p. <sup>M</sup>
camin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		ith	4c. County of De	
1		12801 Holling 5. Social Security Number 6. Se		last birthday)	If Under 1 Year	Bowie If Under 24 Hr		Prince Ge	eorges irthplace (State or Foreigr Country)
ral tor			⊒м 2√⊒F 82	Yrs.	Months Days	Hours Mir	March		ryland
		10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits
	Director	MD Prince	Georges 1	Bowie					1 ☑ Yes 2 ☐ No
	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	eral	12801 Hollins Pl	ace 12. Was Decedent Ever in U	6 12	20716	licagnia Origin?	Specify Vec or No	United Sta	
	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of H f Yes, specify Cubi 1 ☐ Yes 2 ☑ No		rto Rican, etc.)	Black, Wh	ite, etc.
	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi	Year or Dates:	16a Dece	ient's Usual Occur	ation		16b. Kind of Busines	
	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give life.	kind of work done DO NDT use retired	during most of w	orking		,
	Com	6th	none	P	rinter			US Govern	ment
	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
	ဥ	Charles Nighteng		10h Maili	- Add (Chana		P. Sydno	or, City or Town, State,	7i- Ondo)
		19a. Informant's Name/Relationship (T) Debra Spratley	niece	11	Hollins			20716	Zip Code)
		20a. Method of Disposition 1  Burial 2  □ Cremation 3  □			sition (Name of natory or other plac		Date	20c. Location - City o	r Town, State
		` 4 □ Denation 5 □ Other (Specify	Han		Memorial			Landover,	
once		21 Signature of Juneral Service Licent	gee W	1	Name and Addre			nines Funer gton, DC 2	al Home 10017
n al er	edical Examiner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	a. Cardiorespi  Due to (or as a conseq b. Lung Cancer  Due to (or as a conseq c.  Due to (or as a conseq d.	uence of): uence of):	Arrest				5 months
	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 3 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	alivery Day Year
	ρ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco use contribute Yes 2 No 3 ☐ F	to the cause of death?
	Completed							an 24b. Were a prior to death?	
- 1						26. Place of De	1 ☐ Yes eath (Check only o		3 2 110
	0	25. Was case referred to medical							
- 1		examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Oth			dence 6 ☐Other (Sp.	ecify)
	To Be	examiner?  1 Yes 2 XNo  27. Manner of Death  1 XNatural 5 Pending	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing	Home 5 🖾 Resi	dence 6 □Other (Sp. how injury occurred	ecify)
	To Be	examiner?  1 Yes 2 XNo  27. Manner of Death  1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	er: 4 ☐ Nursing y at k?	Home 5 🖾 Resi 28d. Describe	how injury occurred  Street and Number or F	
	Certification; To Be	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifician: To the best of my known iner: On the basis of examina	28b. Time of Injury	28c. Injur Wor M 1 □ eet, factory, office	er: 4  Nursing y at k? Yes 2  No	Home 5 A Resi 28d. Describe 28f. Location (. City or Total	how injury occurred  Street and Number or F wn, State)  cause(s) and manner a	Rural Route Number,
	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only 2 Medicel Exam	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifications)	28b. Time of Injury	28c. Injur Wor M 1 □ eet, factory, office	er: 4 Nursing y at k? Yes 2 No ne, date and place	Home 5 A Resi 28d. Describe 28f. Location ( City or To	how injury occurred  Street and Number or F wn, State)  cause(s) and manner a	Rural Route Number, is stated. e to the cause(s)
	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Robatural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Cartifying Phyone)	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifician: To the best of my known iner: On the basis of examina	28b. Time of Injury	28c. Injur Wor M 1 = eet, factory, office	er: 4 Nursing y at k? Yes 2 No me, date and place pinion, death occurrence	Home 5 A Resi 28d. Describe 28f. Location ( City or To	how injury occurred  Street and Number or F wn, State)  cause(s) and manner a date and place, and du	Rural Route Number, is stated. ie to the cause(s)
III dilector	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Robatural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Cartifying Phyone)	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifiner: On the basis of examina and manner stated.	28b. Time or Injury  Dome, farm, stry  wiledge, deatt tion and/or in  May  n 23a) (Type,	28c. Injur Wor M 1 = eet, factory, office occurred at the tir vestigation, in my occurred at the tir D0056	er: 4 Nursing y at k? Yes 2 No ne, date and place pinion, death occurs on number 5791	Home 5 A Resi 28d. Describe  28f. Location (. City or Tot  2e, and due to the curred at the time,	how injury occurred  Street and Number or F wn, State)  cause(s) and manner a date and place, and du  29d. Date signed (Mon	Rural Route Number, is stated. ie to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 03825 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Estela Α. Frechette Jan. 15, 2004 12:35AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

May 1, 1909 National Lutheran Home Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 532-40-6214 1 ☐ M 2 ☐ XF 94 Director Chile Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits Md. Montgomery Rockville 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yoo Specify: þ Specify: White 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Homemaker other At Home 7 is marked othe traumatic evant, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic evant <u>once.</u> 18. Mother's Name (First, Middle, Maiden Sumame) Be Abel Reyes Dorila Rojas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myles Frechette - Son 7204-Panorama Dr., Derwood, Md. 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory-1/17/04-Alexandria,Va. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.W Hysong Co., Inc.
6510-16th St., NW. Wash, DC.
aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse uence of) Examiner 27 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death signed by the a id be detached fo 5 Other (specify) o 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 HNO 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an page 2 autopsy performed Division of Vital 1 Yes 2 No director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this nerel Diractor: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 F atural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karesh- 9701-Veirs Dr., Rockville, Md. 20850 Dr.Charles W. 31. Date filed (Month, Day, Year) State Registrar

		For State Registrar	State of Ma	ryland / Depa	artme		and Me	ental Hyg		2004	03826
		Negistrar     Name (First, Middle, Last	t)	-				2. Date of Deat	1		3. Time of Death
Physic	ian	Florence Eliz		le Fenton				January	21	2004	12:20P M
/Med		4a. Facility Name (If not institution, give			4b. Cit	ty, Town, or Location			7	ounty of Death	
Exami	ner	2538 Rutland Roa			I	Davidsonvi	11e		Anı	ne Arun	de1
Funeral		5. Social Security Number 6. Se	3x 7. Age	(In yrs. last birthday)			r 24 Hrs. Min.	8. Date of Birth (Month, Day, Dec. I	Year)	9. Birth	place (State or Foreign
Director		169-28-7837	□M 20XF	76 Yrs.	Month	Days Hours	Willi.	Dec. 1	9,192	27 Penn	sÿlvania
2		Usual Residence of Decedent		400 City Town and							10d. Inside City Limits
rylar		10a. State 10b. County		10c. City, Town or Lo							1 ☐ Yes 2 No
e Ma	5	MD Anne Aru	ndel	Davids							
ith th or 28	Director	10e. Street and Number			10f.	Zip Code		10	-	n of What Cou	ntry?
ath with the Marylan 123s or 28s-f show	<u>e</u>	2538 Rutland Ro				21035	sining (Cons			SA . Race - Ameri	can Indian
or de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ X			cedent of Hispanic Or pecify Cuban, Mexica		Rican, etc.)	14	Black, White,	
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	·	1 🗆 Yes	2 □Xio Specify	<i>'</i> :		S	pecify: Whi	te
CLINION (INC.) (INC.) (Inc.) (	ed t	15. Decedent's Ed		16a. Dece	dent's U	sual Occupation			16b. Kind	of Business/In	
10 27 nin 72	Completed	(Specify only highest gra	de completed)	(Give	DO NOT	sual Occupation work done during mo: "use retired)	st of workin	g			
the second	E O	Elementary/Secondary (0-12)	College (1-4or 54 5+	"   ]	[eacl	her			Pub.	lic Sch	ools
Id Z il Hygie other sent, it	Be C	17. Father's Name (First, Middle, Last)				18. Moth	ner's Name	(First, Middle, A	faiden Su	ımame)	
# 4 a b #	To B	Michael McHale				B1a	nch W	hite			
2 shou and M ls mar ls mar aumat	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Addre	ess (Street and Numb	er or Rural	Route Number,	City or T	own, State, Zip	o Code)
		Brian K. Fenton /	Son	2538	3 Rut	tland Rd.	Davi	dsonvil			
re, Maryla		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (A	Vame of or other place)	Da	ate :	20c. Loca	tion - City or T	own, State
Pages nent of nut: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐  *4 ☐ Donation 5 ☐ Other (Specify				Cemetery	1-28	-2004	Chel:	tenham,	MD.
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Licer	e 11	2:	2. Name	and Address of Facil	lity Be	all Fun	era1	Home	
p ggrage		+ Comm	Provell			NW Crain	Highw	ay Bow	ie, l		15
Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each line Conge	the death. Do not en s. stive Hear	terthe m	node of dying, such as ailure	s cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death 2 days
/Medica Examine		resulting in death)		consequence of): ythemia							1996
bed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):							1995
/ bu, e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):							1
<b>58/6</b> ifficate be g physic as the bu	dical		d								
	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Tenair	pregnancy			230	d. Date of deliv	
P.O. BOX nat the death cer d by the attendin	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at t 9 Unknown		Other					Month	Day Year
	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	underlyin	g cause given in Part	1.		acco use		the cause of death?
w require been si should t	Completed							24a. Was a		24b. Were auto	opsy findings available
Hec he lav e has	mg							autops	ned?	death?	ompletion of cause of
VITAL INGLIANT TO CONTRIBUTE T	e C	25. Was case referred to medical				26 Plac	e of Death	1 ☐ Yes 2 (Check only on	No	1 🗆 163	2010
VIII sicia cert	00	examiner?	Hospital:	nt 2 ER/Outpatie	nt 3□	Other	Jursing Hon	s. 4'		Other (Speci	(v)
Phys r this	n: To	27. Magner of Death	28a. Date of Injur (Month, Day			28c. Injury at Work?		8d. Describe ho			,,
Oding tune	i i	1 Natural 5 ☐ Pending 2 Accident investigatio		Year) Injury	М	1 Yes 2	]No				
DIVISION Of VITAI HECONGS, Hospital or Attending Physician: The law requires the hours after death. 24 hours after death. I Funeral Director: After this certificate has been signe stelly filled in by the funeral director, page 2 should be on the formal of the formal director.	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, fac	tory, office	2	8f. Location (St. City or Town		Number or Run	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	edical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	nysician: To the best on miner: On the basis of and manner sta	examination and/or in	th occurr	ed at the time, date a ion, in my opinion, de	and place, a eath occurre	nd due to the ca od at the time, da	use(s) ar	nd manner as s lace, and due t	stated. o the cause(s)
To th within Fo th	Me	29b. Signature and title of certifier	010			29c. License number		2	d. Date :	signed (Month,	Day, Year)
		> = PL	)/(	> M	C	D26199			Janua	ary 21,	2004
(in	)	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)						
(10)		Emily Ulmer, M.D		efense Hwy		ite 201	Croft	on, MD.	2111	4	
S Regis	tate trar	31. Date filed (Month, Day, Year)  JAN 2 2 2004	32. Registra	r's Signature	41						

		For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F ertificate of			eg. No.	04	0382
Physicia /Medica	al	Decedent's Name (First, Middle, Last,  JOYCE MARIE FRA	ZIER				2. Date of Deal Month January	Day 17, 20	Year 004	3. Time of Death
Examine	er	4a. Facility Name (If not institution, give Heartland Healt  5. Social Security Number 6. Sec	h Care Ce	nter (In yrs. last birthday	4b. City, Town, c Adel  If Under 1 Year		rs. 8. Date of Birth	1	nce G	eorge
Funeral Director			M 20XF 62	Yrs.	Months Days	Hours Mi		1941	D.C	
23a or 28a-f ehow	Director	DC 10b. County		Washing	ton					0d. Inside City Limit
23a or 2	al Dire	10e. Street and Number 461 H Street, N	W		10f. Zip Code 2000.	1	1	0g. Citizen of V USA	Vhat Cour	ntry?
ra mous and ocali will file mayand natural, or itama 23a or 28a-1 chow dical Examiner must be notified at	Completed by Funeral	11. Marital Status  1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ Mo	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		k, White,	ean Indian, etc. ack
than	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+	(Give	edent's Usual Occup a kind of work done DO NOT use retire sekeeping	during most of w	vorking	16b. Kind of Bu	lowe:	
oven even	To Be Co	17. Father's Name (First, Middle, Last)  Douglas Frazier				Mildre	ame (First, Middle, Med Banks	Maiden Sumam	e)	
Health a m 27 is ther train		19a. Informant's Name/Relationship (Ty Angela Long/Dau 20a. Method of Disposition		5703	3 18th Ave	e, Hyatt	Rural Route Number SVILLE M Date			
rtment o		1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lidens	-	Glenwood	matory or other place. Cemetery	1/2		washing	ton,	DC
Depa Impo any ii		23a. Part1. Enter the disease, or compl	trick /x	me e	500 Aller	ntown Rd	l, Camp Sp	rings,	MD 2	0748 Approximate
nysicia he bur	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):  consequence of):	11 Cqsa Jelli tu	10 vasci	nlar di	3.0030		
by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	l3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date Mor	e of delive	ory Day Year
en signed b	۾	Part II. Other significant conditions con	ntributing to death but	1100	underlying cause giv	en in Part I.		acco use contri s 2 □ No		e cause of death? ably 4 □Unknov
	Completed	Perephersel vo	1 ascular	diseas	e.		24a. Was ar autops perform 1 Yes 2	pled? d	rior to cor eath?	osy findings availat npletion of cause of 2XNo
this cert	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatie		er: 4 Nursing	eath (Check only one Home 5 - Reside 28d. Describe ho	nce 6 □Othe		()
4 hours after death, Funeral Director: After tely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)		Yes 2 □ No	28f. Location (Str City or Town		or Or Rura	l Route Number,
Funer Funer tely fill	edical C		sician: To the best of ner: On the basis of e and manner state	examination and/or in						
within To the comple	M	29b. Signature and title of certifier	Tus		29c. Licens D 42	4 03	29	d. Date signed		
11)		30. Name and address of person who co		ath (Item 23a) (Type						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day JAN 16, **GUTTERMAN** 2004 /Medical 4:05A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE NURSING HOME ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea. 10/29/1910 9. Birthplace (State or Foreign Country) NEW YORK **Funeral** Days Min. Months Hours 1□M 2∏F Yrs Director 93 452**-**03-8549 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 17 is marked other then "natural", or items 23a or 28a-f show troumatic event, the Medical Examinat must be inclined at 10d. Inside City Limits Director 1 ☐ Yes 2 No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 ADCLARE ROAD 20850 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No δ Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT BUSINESS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked oth any injury or other treumatic event SIRs. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) HARRY LIPTON NELLIE BERKOWITZ ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN G. TANENHOLTZ/DAUGHTER 12304 OLD CANAL ROAD, POTOMAC, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State S P 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JAN 20, 2004 FALLS CHURCH, VIRGINI \* 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORIUM 21. Signatur Fundal Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT HOURS /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical the as esn nse IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Year Day 5 Other (specify) ed by the detached is Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be PNEUMONIA, CONGESTIVE HEART FAILURE, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 ₽ No director. Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient 2 EP/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 - Homicide To the Hospitel within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and tifle of certified 29c. License number 29d. Date signed (Month, Day, Year) D0059499 JANUARY 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MARY CALLSEN, 6000 EXECUTIVE BLVD, SUITE 300, ROCKVILLE, MARYLAND 20852 31. Date filed (Month, Day, Year) JAN 22 32. Registrar's Signature 2004 racks Registrar

		-		State of Maryla	nd / Depa	artment of I	Health and	•		004	03829
			- State Registrar AMEND ITEM #  1. Decedent's Name (First, Middle, Last)	LOa-f PER FH	L_G8367°/	723704		2. Date of De	Reg. No.		3. Time of Death
	Physicia	an		Lexander GRO				Month	Day	Year	
	→ /Medic	al	4a. Facility Name (If not institution, give st		.,	4h City Town	or Location of De	January		2004 unty of Death	5:30 A M
	Examin	er	1316 Fenwick Lane				er Sprin			ntgome	
	-		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir			plece (State or Foreign intry)
75	Funeral Director			M 2□F 95	Yrs.	Months Days	Hours Mi		1908		ecticut
			Usual Residence of Decedent								
	ylan		10a. State 10b. County	10c. C	City, Town or Lo	cation IELBOURNI	7				10d. Inside City Limits
	a-f s	cto	FL BREVARD Montgom	ery	Sil	er Sprin	12				1 ☐ Yes 2 ☐XNo
	क्ष प्रमुख्य विकास	Director	10e. Street and Number TIMBER WA	Y		10f. Zip Code	32935-57	40	10g, Citizen	of What Cou	intry?
	23a		1316 Fenwick Lane	<del>#140</del> 9		2-01	<del>)10</del>			d Stat	
	r dea	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D= 14.	Race - Ameri Black, White	
36	or It	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No WW If Yes, Give	VII	1 ☐ Yes 2 🔀 No	Specify:		Sp	ecify: wh	ite
Ö	hour:	g p		Year or Dates: Kore		dent's Usual Occu	nation		16h Kind	of Business/fr	ndustry
5	n 72 nat	Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of v	vorking	TOD. KING	J. 60311103311	ideatry
2	within then	E C	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ntist			Dent	ta1	
5	filed Hygi ther ant, I		17. Father's Name (First, Middle, Last)		DCI	ic 13c	18. Mother's N	lame (First, Middle			
an	d be ental	To Be	Louis Grower				Anni	e Josepha	son		
Maryland 21215-0036	shoul mark mark	F	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree		Rural Route Numb		wn, State, Zi	ip Code)
S	od 2 Ith ar 27 is		Marvin Grower, Son		1615	Hugo Cin	ccle, Si	lver Spri	ing, M	D 209	06
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amount in item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Item Medical Examinational Landillad at ODGs.		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other pla	aca)   01	/2 <sup>Date</sup> 04	20c. Locati	ion - City or T	own, State
D L	Pages nent of nr: H		1 Donation 5 Other (Specify)	moval from State	•	Nationa	, ,		Arline	ton.	57 A
₫	ortar	Ť	21. Signature of Fun rai Servie License					Funeral			V 21
B	Depar Impor any ir				To	rchinsky	Hebrew	Funeral	Home,	Inc.	20012
à	5 Y 9		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the de	ath. Do not en	er the mode of dy	ing, such as card	liac or respiratory a	irrest,	, 100	20012 Approximate Interval Between
R	Dhysisian		Immediete Cause (Filial	cause on each line.	GA	Ton. A					Onset and Death
	Physician /Medical		disease or condition resulting in death)	Coronas Due to (or as a conse	equence of):	7	weose	,			
16 16 d	Examiner				,	V					
3	i i	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as a conse	equence of):						
760,		cal	d.								
68	5 g 2	Med	is service							Manage	
Box	th cert endir r use	A/VE	230. Was decedent pregnant	c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	nancy etal death 3 [	Ectopic pregnanc	cy		23d	i. Date of deliv Month	very Day Year
	it the death certif by the attending tached for use a:	sicia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4☐Pregnant at time of 9☐ Unknown		Other (specify)				MOLIGI	Day Tour
P.O.	at the by th	Physician/Med	9 Unknown						-		
	res tha signed be det	by	Part II. Other significant conditions conf	ributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.				the cause of death?
ord	w require been sig should b	ted	to general reac	& failur				- 1	Yes 2□N	10 3   P10	Dably 4 Conknown
Vital Records,	has be	ple	hyperterson					24a. Was	DSV	prior to co	opsy findings available ompletion of cause of
<u> </u>		Completed by	dementia						ormed? 2 ₽ No	death? 1 ☐ Yes	2 □ No
ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					Death (Check only	one)		
	\$ w 5	2	1 ☐ Yes 2 ØNo		☐ ER/Outpatie	" 30 DOX	ther: 4 \( \text{Nursing}	Home 5 Res			ify)
ם	ng Ph fter th ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	W	ork?	28d. Describe	how injury or	scurred	
Division of	ttendi death. ctor: A y the fu	Certification:	2 Accident investigation				Yes 2 No				
Ž	ter d irect	ij	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe		reet, factory, office	)		Street and N wn, State)	umber or Rui	ral Route Number,
	urs al										
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical		er: On the basis of exami							
	To the l within 2. To the I	Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date si	igned (Month	Day, Year)
)	7 ¥ 7 8		O Signature and the or cashing	5					1/-	> /01	6
	6+1						11743		1/2	-/ -4	
			30. Name and address of person who cor	npleted cause of death (It	Valto . D	Prints	w Him	Wark	DC 20	1307	
	Sta	to	31 Date filed (Month, Day, Year)	32. Pegistrar's Sig	gnature /	1	1. Make	Wash.	-	J 1	
	Regist		JAN 22 200	4 Seneva	19	spork	2				

		RegistrarAMEND#5pc  1. Decedent's Name (First, Middle,		. , LL -3/4 , L' L. L.	<u> </u>	rtificate		7	2. Date of Dea Month	ith Day	Yeer	3. Time of Death
Physicia /Modio	_	Philomena	Grifone						January			4:40 P
Medic/ Examin	_	4a. Fecility Name (If not institution,		nber)		4b. City, To	wn, or Loc	ation of Deat	h	4c. C	ounty of Deet	th
		Montgomery Hos					ville				ntgome	
uneral irector		57878, - 28, -2990 57878, -28 -2902	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 77	last birthday, Yrs.	Months (		Under 24 Hrs. ours Min.	8. Date of Birtl (Month, Day Aug. 19	, Year) , 192	6 Was	thplece (State or Fore buntry) shington,
3 12	}	Usual Residence of Decedent  10a, State 10b, County		10c. Ci	ty, Town or L	ocation						10d. Inside City Lim
f sho	ō	M 1 1 . M			S 1 1 17 0	r Spri	na					1 ☐ Yes 2 🔀
of other than "neturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at	Funeral Director	Maryland Montgo	mery		DIIVE	10f. Zip C				10g. Citize	n of What Co	ountry?
3e of	<u> </u>	3679 South Leis	sure World	d Blvd.		2	0906				USA	
ms 2	ner	11. Maritat Status	12. Was Dece Armed For	dent Ever in U	J.S. 13.	Was Deceder	nt of Hispa	nic Origin? (S lexican, Puer	specify Yes or No- to Rican, etc.)	14	. Race - Ame Black, Whit	
or ite	F	1 Never Married 2 Marrie		2 X No		1 ☐ Yes 21		pecify:	,		pecify: Whi	
LEXT	d by	3 Widowed 4 Divorced	Year or Da	ates:	1 10 0							
Thet	Completed	15. Decedent' (Specify only highest			(Give	edent's Usual ( e kind of work DO NOT use	done durin	g most of wo	rking		of Business	•
then	m d	Elementary/Secondary (0-12)	College (1	-4or 5+)	Dire	ctor of	Eás	tern Co	operative	Can	cer Re	search
vent, the Me	ပိ	17. Father's Name (First, Middle, L	.ast)			ncorog			me (First, Middle,			
	To B	Michael Grifor	ne.					Carme	la Albar	iese -		
EE	-	19a. Informant's Name/Relationsh			19b. Mail	ing Address (	Street and	Number or Ru	ural Route Numbe	r, City or 1	own, State,	Zip Code)
N 5		Donna M. Cardar	no/ Niece		1804	Judic	ial W	lay, Cr	ofton, M	D 21	114	
Important: If Item 2 eny injury or other		20a. Method of Disposition	2	20b.	Place of Disp cemetery, cre	osition (Name matory or other Heaven	of er place)	Janu	Date 17	20c. Loca	tion - City or	Town, State
# 61		1 ☑ Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (Sp		Ga	Cemet			•	2004	Sil	ver Sp	ring, MD
y inju		21. Signature of Funeral Service L	icensee				Address of	Facility	Funeral	Home	- Inc.	
8 2 2 3		23a. Part1. Enter the discore, or	Janeps		1.5	00 Uni	versi	ty Blv	dW.,_S	ilve	r_Spri	ng, MD 2090 Approximate Interval Between
hysician and ledical aminer transit	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (	static or as a consec or as a consec or as a consec	quence of):	odgkins	s Lym	phoma				less than
by the attending phy tached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of	al death 3	□Ectopic preg □ Other (spec				23	d. Date of del Month	livery Day Year
gned be de	d by P	Part II. Other significant condition Anemia, Thrombo			sulting in the	underlying cau	ise given ir	Part I.	- 10	bacco use		o the cause of death?
been si should	ete								24e. Was	an	24h Were a	utopsy lindings availa
	m d								autop	rmed?	prior to death?	completion of cause
_ 0		25. Was case relerred to medical					20	Blace of Do	1 ☐ Yes ath (Check only o	2 🔯 No	1 Li Yes	2 □ No
ricate has or, page 2	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2	☐ ER/Outpatie	ent 3 DOA					AOther (Spe	Hospice
certifi		27. Manner of Death	28a. Date	of Injury	28b. Time Injury	ol 28	c. Injury at Work?		28d. Describe h			7, -
this certifi		1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	,,		М		2 □ No				
fter this certifu	atio	3 Suicide 6 ☐ Could r	ned 289. Place	of Injury - At I ng, etc. (Spec		treet, factory,	office		28l. Location (S City or Tox	Street and m, State)	Number or R	ural Route Number,
fter this certifu	ertification	3 Suicide 6 Could r 4 Homicide determi	001101			th occurred at	the time,				nd manner as	
fter this certifu	dical Certification:	4 Homicide determ	g Physician: To the Examiner: On the b	asis of examin			n my opinio	on, death occ	urred at the time,	date and p		e to the cause(s)
fter this certifu	Medical Certification	4 ☐ Homicide determine de	g Physician: To the Examiner: On the b and man			nvestigation, i	n my opinio License nu			·	lace, and due	th, Day, Year)
within 24 hours after treath.  To the Funerel Director: After this certifut pompletely filled in by the funeral director.		4 Homicide determ  29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the Examiner: On the b and man	asis of examin		nvestigation, i				·	lace, and due	
fter this certifu		4 Homicide determ  29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the Examiner: On the b and man	asis of examin ner stated.	ation and/or i	29c.				·	lace, and due	

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day G 4 GREGN JAISON 1310 M 2000 4 mi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD WINTY GENERAL COUNTSIA Inmaro 123ATIAZ If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1፟፟፟∭M 2□F **Director** 140-30-7248 64 NEW JERSEY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1X Yes 2 ☐ No Directo MARYLAND HOWARD ROCKY GORGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8351 SAND CHERRY LANE 20723 Funeral U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 INFORMATION SECURITY DEPARTMENT OF DEFENSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked ot Be ၉ LOUIS SAMUEL GREEN FORGASH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lybs 1.
Lyartment of Hea.
Important: If Item 2;
any injury or other tra LYNN KLEIN GREEN/WIFE 8351 SAND CHERRY LANE, ROCKY GORGE, MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM. GARDENS 01/11/2004 OLNEY, MARYLAND 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, TNC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funeral Service Licenses Donald ( 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIL Physician SITURIC 24 INVES /Medical Due to (or as a consequence of): Examiner PANZRIATIC < months METACTATIC CANCER Sequentially list conditions, if any leading to model cause. Enter Underlying Cause (Disease or injury Due to (ur as a consequence of) certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death ed by the a 5 Other (specify) P.0. 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DIAGGTES moultws 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ 🐼 o 24a. Was an autopsy performed? Yes 2 this certificate 1 Yes Division of Vital Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 036974 10 JAN 9 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DAV DAVID NYANJOM, M.D. LITTLE PACIFISHT PARKUM 31. Date filed (Month, Dey, Year) 32. Régistrar's Signature State JAN 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 191 cque1 /Medical 4b. City Town, or Location of Death 4c. County of Death 4a Facility Nam (If not institution, give street and number) **Examiner** 0/429/19 Versing JUSE If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In-yrs. last birthday) 8. Date of Birth (Month, Day, Y 12/31/28 Birthplace (State or Foreign Country) 5. Social Security Number Funeral Hours 1□M 2K F 578-42-3366 75 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylen Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Exampler must be notified at 1 DYes 2 □ No Funeral Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21044 6334 Cedar Lane United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: ģ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nellie Timmons Sandy A. Levi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 4808 Moorland Lane, #913, Bethesda, MD. 20814 Travis Levi/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/04 Bladensburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7400 Georgia Avenue, NW, Wash. DC 20012 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Eastminer Due to (or as a consequence of) Examiner signed by the attending physician end id be deteched for use es the buriel-trensit Attanding Physician: The law requires that the death certificate be exacuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying pause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ After this certificete hes been signe funeral director, page 2 should be a 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Be Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation After 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide efter To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 108 05 31. Date-filed (Month, Day, Year) 32. Registrar's Signature State JAN 23 2004 Registrar

AMEND#20erMD1/30/04,BM,State of Maryland / Department of Health and Mental Hygiene 1- For MEND#23aperMD1/23/04,BM,MCO Registra/WEND#25,27,28a-fperME1/23/04,BM,MC Certificate of Death Reg. No. 03833 2. Date of Death 1-15 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** am grane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner salumore 105 n Secom WITU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WASHINGTON, DO 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 87 578-52-0312 0/31/1916 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County in than "natural", or Itams 23a or 28a-f show the Medical Examinar roust bu notified at KENSINGTON 1 ☐ Yes 2 No MARYLAND MONTGOMERY Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 10225 FREDERICK AVENUE #700 20895 U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Agned Forces?
1 Yes 2 No
If Yes, Give UNKNOWN 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) "UNKNOWN" FEDERAL GOVENMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SARAH SHAFER MORRIS ROBERT GRANE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 0850 19a. Informant's Name/Relationship (Type, Print) 230 NORTH WASHINGTON ST, SUITE 400, ROCKVILLE, MD CARLYLE M. RUBINOW/PERSONAL REP. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/28/2004 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State B'NAI ISRAEL CEMETERY OXON HILL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORTAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Wooden Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.

Immediate Cause (Final ASPLICATION Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Disloged Tracheostomy Tube **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day ত্ 4☐ Pregnant at time of death 5 Other (specify) P.O. I the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð sign 1 be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Tyes Division of Vital Physicien: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospitel or Attending Pl 24 hours after death. Funeral Director: After the Certification: 5 Pending 1 ☐ Yes 2 ☐No 2 X Accident 3 ☐ Suicide Jan.15, 2004 11:30 A<sup>M</sup> investigation Dislodged tracheostomy tube 6 Could not be determined Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide nursing home Baltimore, M To the Hospital within 24 hours a To the Funeral D 22 So. Athol Ave The Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number 30\_Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheel Marien 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racks 23 JAN 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 7:30 P M ALBERT EDWARD GORSUCH 16 2004 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Frederick Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept. 7, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Washington, D.C 1928 75 578-30-8925 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☑ Yes 2 ☐ No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 United States 905C Blue Leaf Court 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 反 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Surveyor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mamie Penelope Elliott Albert Fayette Gorsuch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 905C Blue Leaf Court, Frederick, Maryland 21701 Betty J. Gorsuch/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Suitland, Maryland 4 Donation 5 Other (Specify) 2004 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 21. Signature of Funeral Service Licensee 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MPHYSEM OYEAR resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or a jury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? METASTATIC COLON 1XYes 2 No 3 Probably 4 Unknown ANERYSM 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL WASCULAR 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Housel mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary P. Howell, M.D. 65C Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) JAN 2 0 32. Røgistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

by Funeral Director

Completed

Be

2

Physician/Medical Examiner

Be Completed by

Medical Certification; To

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exerpires must be notified at

Physician

/Medical

**Examiner** 

use as the burial-transit and

attending physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:

12

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

		ı	For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of H	ealth an D <i>eath</i>	d Mental Hy	giene Reg. No.		0383	15
			Decedent's Name (First, Middle, La	ist)		-			2. Date of De	ath		3. Time of Deat	h
	Physicia /Medic		HYMAN			GO	OLDSTEIN		JANUAR	Day 7 22		2 ° 10A	М
	Examin		4a. Fecility Name (If not institution, gi	e street and nu	n <i>ber)</i>		4b. City, Town, or	Location of D			County of Death		
			COLLINGSWOOD NUR	SING HO				KAITTE			MONTGO	MERY	
	Funeral			Sex 1⊡rM 2□F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Da 10 / 07 / 1	th y, Year)	9. Birth	place (State or Fore ntry)	e <i>ign</i>
4	Director		052-10-2891 Usual Residence of Decedent		88	115.			10/0//1	.915	NEW_	YORK	
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Lin	nits
	Mary Firsh	to	NEW YORK BRONX			H	BRONX					1 X Yes 2 □	No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?	
	th wit	alD	4715 OSMAN PLACE					10470			U.S.A		
	ems ems	Funeral	11. Marital Status	12. Was Deci	edent Ever in U	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin' n. Mexican. P	? (Specify Yes or No uerto Rican, etc.)	-	14. Rece - Ameri Black, White		
20	hours after death with the Maryland urel, or Items 23a or 28a-f show at Examinat must be notified at	by Fu	1 Never Married 2 Married	1 ∐Yes If Yes, Gir	/8 **		1 ☐ Yes 🎗 ☐ No	Specify:			Specify: WH		
Ş	hours tural	d be	3 XWidowed 4 ☐ Divorced	Year or D	ates:	163 Deces	ient's Usual Occupa	ation		16h V:	ind of Business/Ir		
	in 72 n n	ojet	(Specify only highest gi	ade completed)		(Give	kind of work done of NOT use retired	turing most of	working	100. KI	ind of businessyll	luustry	
77	l with jiene. r tha	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	BUSIN	ESS OWNER			HOME	E IMPROV	EMENT	
פ	be filed within 72 hours after death with the Marylan tal Hygliene. Id other than "natural", or liems 23a or 28a-f show event, The Mariksal Examination must be notified at	Bec	17. Father's Name (First, Middle, Las	")				18. Mother's	Name (First, Middle,	Maiden	Sumame)		
<u>a</u>	should be nd Menta i marked umatic ev	To	SAMUEL GOLDSTEIN					BESSIE	WOLFSON				
Maryland 21215-0036	es 1 and 2 should to Health and Ment (item 27 is marked to other treumatic		19a. Informant's Name/Relationship STEPHEN B. GOLDST				-		r Rural Route Numbe KVILLE, MA				
Baltimore,	Pages 1 au nent of Hea int: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Lo	ocation - City or T	own, State	
	it. Pa rtmen rtant: njury	. 1	* 4 ☐ Donation 5 ☐ Other (Special State of Fundamental Service Line		CED		CEMETER		N 25, 200			NEW JERSE	ΞY
Ra	permit. Pages Department of Important: If it any injury or o		21. Schalling Pure Line	11588		ĔĨ 10	OWARD SAG 191 ROCKV	EL FUNI ILLE PI	ERAL DIREC	CTION VILLE	N, INC. E, MARYL	AND 20852	2
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on e	aused the dea ach line.	th. Do not ente	er the mode of dying	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	a ENDST	AGE OBS	TRUCTI	VE LUNG D	ISEASE				Onset and Death	
	/Medical Examiner		resulting in death)		or as a conse								
4	*	<u>.</u>	Sequentially list conditions,	b	ULMONAL (or as a consec								
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				E PULMONA	א עבכ	FASF				
a î	exection and and rial-tra	Exa	that initiated events resulting in death) Last		(or as a consec		L I OLLIOIVI	KI DIO.	шиоп				
8760	death certificate be executed e attending physician and od for use as the burial-transit	dicai		d									
Õ	entification plants	Med	IF FEMALE:										
X Q R	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		oirth 2 Fet	al death 3	Ectopic pregnancy			2	23d. Date of deliv Month	ery Day Year	
o.	at the de by the a tached t	Physician/Me	1 Tes 2 No	4 □ Pregr 9 □ Unkn	ant at time of o	death 5	Other (specify)					,	
J.	de de		Part II. Other significant conditions	contributing to d	eath but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to t	he cause of death?	?
Vital Records,	quires n sign	ed by	PNEUMONIA						152	res 2	□No 3□ Prot	oably 4 Unkno	·
ဝ္ပ		olete	ACUTE DIYOCARDI	AL INFA	RCTION				24a. Was		24b. Were auto	opsy findings availa	mpie
ž	0 - 2	Completed					E		— autop perfo 1  Yes	rmed?	death?	mpletion of cause : 2□ No	or
<u>Ta</u>	rysician: Th	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check only o		10.00		
o   	Physician: r this certific ral director,	To	1 ☐ Yes 2X No	Hospital:	npatient 2	ER/Outpatien		4V IAMIZII	ng Home 5 Resid	dence 6	6 □Other (Specia	(y)	
ono	ing Afte	atlon;	27. Manner of Death  1X Natural 5 □ Pending 2 □ Accident investigate		of Injury th, Day Year)	28b. Time of Injury	Work	rat (? Yes 2 ∐ No	28d. Describe I	now injur	y occurred		
Division	or Al	Certification;	3 Suicide 6 Could not l 4 Homicide determined	28e. Place buildi	of Injury - At h	nome, farm, stre ify)	eet, factory, office		28f. Location (\$ City or Tox		d Number or Run )	al Route Number,	
_	spits ours ours nere fille		29a. Certiffer Certifying P	hysician: To the miner: On the b	best of my kn	owledge, death	occurred at the tim	e, date and pl	lace, and due to the occurred at the time,	cause(s)	and manner as s	tated.	
	the Hosthin 24 h	Medical	29b. Signature and title of certifier	and man	ner stated.		29c. License				e signed (Month,		
)	P 1		Meret	10010	~			839			JARY 2.2.		
	15		30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type	Print)			CELLY	23222 6.6.9		
			DR. GARY RAFFEL,		•		ŕ	202A, 1	BETHESDA,	MARY	ZLAND 2	0814	
	Sta Registr		31-Date filed (Month, Day, Year)  JAN 23 2	32. F	egistrar's Sign	ature /	Sparks						

	1	For State Registrar	State of iv	iarylari				Death	ina ivie			200	-	0383
 Physicia		1. Decedent's Name (First, Middle, Las	t)						2	. Date of Death Month		Yea		3. Time of Death
/Medic	_	MORRIS	GOLDEN						J	ANUARY	-		1.7	7:00A
Examin	_	4a. Fecility Name (If not institution, give	street and number	r)		4b. City	, Town, or	Location o	f Death		4c.	County of D	eath	
		MANOR CARE					BETHE		2411		The second of Birth and h. Dey, Year and the profession of Birth and h. Dey, Year)  10g. Citizen of What Company of Company of Birth and h. Dey, Year)  10g. Citizen of What Company of Com			
Funeral		5. Social Security Number 6. Se	7. A DM 2□F	ige (In yrs. <b>90</b>	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min. 8	. Date of Birth (Month, Dey,	Year)	9. 8	Birthplac Country	e (Stete or Forei
Director	-	5//-22-52/4		90	TIS.				A	PRIL 4	19	3 MA	RYL	AND
and *	⊦	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					_		10d.	Inside City Limit
Aaryi F sho	5													1 Yes 2 N
within 72 hours after death with the Maryland ene.  Han "naturel", or Items 23e or 28e-f show the Medical Esamirar must be notified at	Directo	MARYLAND MONTGO  10e. Street and Number	DMERY		ROCKV		p Code			10	la Citi:	en of What	Country	7
S o o	0		TO DOTTE			10 2								
18 23 The 23	Funeral	2606 OAKENSHIE	12, Was Deceden	t Ever in U	S 13.1	Was Dece	2085		nin? (Speci	ty Yes or No-				
It a	'n	1 Never Married 2 Married	Armed Forces	;?		f Yes, sp	ecify Cuba	n, Mexican	, Puerto Ri	can, etc.)				
6 -	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates			1 🗆 Yes	2 XNo	Specify:				Specify:	WHIT	Œ
atura de la companya	ed	15. Decedent's Ed	ucation		16a. Dece						6b. Kir	d of Busine	ss/Indus	itry
	Completed	(Specify only highest grad		- F - \	(Give	kind of w DO NOT	ork done d use retired	during most ()	of working					
iene	E	Elementary/Secondary (0-12)	College (1-4o	( 5+)	ME	RCHAI	ΥT				-	ጀዋብሮፑዩ	V	
Hygi other	Bec	17. Father's Name (First, Middle, Last)	***************************************			IX COLUMN		18. Mothe	r's Name (i	First, Middle, M				
ental Ked c	To B	PHILIP GOLDEN						P.O	CA CT	GARMAN				
marke	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Addres	s (Street a				City or	Town, State	e, Zip Co	ode)
trau		LOIS M. GOLDEN -	DAUGHTER		5040	DAN	PT.A	CF N	IJ IJAC	HTNCTO	J T	C 200	16	
Health Health Health Hear to	1 1	20a. Method of Disposition	DHOUGHER	20b. F	Place of Dispo	sition (Na	me of		Dat		_			, State
		1 Burial 2 Cremation 3		8	emetery, crei									
Tan tan	1	*4 □Donation 5 □ Other (Specify		hub	EAN ME	17-				/04	OLL	EY, M	ARYI	AND
permit. Fagges rature should be mer while to hours are been must be marginal permit. Figges the strength and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 28s-f show any injury ocother traumettic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen.	Stotel	inge	DA 11	NZAN: 70 RO	SKY G OCKVI	ss of Facilit OLDBE LLE P	RG ME	MORIAL ROCKVII	CHA	PEL, MD_2	INC. 0852	
Thysician // Medical /	al Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, reauting to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	Due to (or a DYSPH Cue to (or a Due to (or a	AGIA	uanca of):	UKE								
ine deain certific y the attending p iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fete	el death 3	⊒Ectopic p □ Other (s	pregnancy specify)				2		delivery Da	ay Year
90	d by	Part II. Other significent conditions of DEMENTIA	ontributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.					e to the o	
as been si 2 should l	ete									242 Who a		24h Word	autone	findings avails
ate has page 2	Complete		· · · · · · · · · · · · · · · · · · ·							autops	red?	prior death	to comp	letion of cause
this certificate	Be (	25. Was case referred to medical examiner?						26. Place	of Death (	Check only on	)			
direct	2	1 ☐ Yes 2 🙀 No	Hospital: 1 Inpa	itient 2	ER/Outpatier	nt 3 🗆 🗅	OA Oth	er: 4 🕱 Nu	rsing Home	5 🗆 Reside	nce 6	Other (S	Specify)	
		27. Manner of Death	28a. Date of Ir	njury Day Year)	28b. Time o	f	28c. Injury	y at	28	d. Describe ho	w injur	occurred		
وَ لا يَ	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Jay roar)	lingury	м		Yes 2 🗆	No					
= <u>5</u> = =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of	Injury - At h etc. (Specif		reet, facto	ry, office		28				Rural R	loute Number,
24 hours a Funeral I	edical C	29a. Certifier 1 Certifying Ph	ysician: To the be niner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tin n, in my o	ne, date an pinion, dea	d place, an th occurred	d due to the call at the time, da	use(s) ite and	and manner place, and c	r as state due to th	ed. e cause(s)
	Me	29b. Signature and title of certifier				25	9c. License	e number		25	d. Dat	signed (Mo	onth, Da	y, Year)
o the	45				1 1 1 1							-		
To the within To the		mVe	1 2111	AAY	V = I = I / I	11								
To the within 2 To the comple		> m Ve	ini	// '	rvill	11	D3	5791			ANU	ARY 2	0, 2	004
To the To the complete		30. Name and address of person who were the work of th	completed cause o	f death (Iter			D3.	5791			ANU	ARY 20	0, 2	004

		·	For State Registrar	State	of Marylar			nt of Ho te of E		nd Me	ental H	lygie Reg.	- / 11	04	03837
	Physici	an	Decedent's Name (First, Middle     PHILTP		TICK						2. Date of Month JANUA		Day 17, 20	Year 104	3. Time of Death 4:00P M
	/Medio		4a. Fecility Name (If not institution			<u> </u>	4b. City	, Town, or	Location of [				4c. County		7.001
	4		116 EAST MEL					EVY C						GOME	
1	Funeral Director		5. Social Security Number 218-34-5256	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. 98	last birthday) Yrs.	Months Months	Days	If Under 24 Hours	Min.	B. Date of (Month, DEC.	Birth Day, Ye	1905	9. Birthp Cour ILLI	
õ	hours after death with the Maryland urel; or Items 23e or 28e-f ehow at Exartal or must be positived at	y Funerai Director	10e. Street and Number  116 EAST M  11. Marital Status  1 □ Never Married 2 □ Marr	Armed F	cedent Ever in Uorces?	J.S.   13.	10f. Z	p Code  208  edent of Hisecrify Cubar	15 spanic Origin , Mexican, F Specify:	n? (Spec Puerto Ri	ify Yes or ican, etc.)	UNI:	14. Race	Vhat Cour CATES e - Americ ck, White,	OF AMERICA
9500-61212	within 72 liene. r then "nat	Completed by	3 Widowed 4 □ Divorced  15. Deceden (Specify only highest Elementary/Secondary (0-12)	's Education t grade completed, College (	DatesUNKNC	16a. Dece (Give life.	dent's Usi	ual Occupa ork done di use retired)	uring most o				LAW	usiness/In	
and	od la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle,  DAVID GLICK	Last)					18. Mother's				KNOWN"	-	
Mary	ss 1 and 2 should of Health and Men item 27 is marke cother traumatic		19a. Informant's Name/Relations	100	NT A NI				MAN 48			EN C	LANE	State Zin	TE <sup>60</sup> 700
altimore,	Pages 1 and nent of Health out: If Item 27 ury or other to		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from	20b.	Place of Dispo cemetery, crea	sition (Na natory or	ume of other place	)	Da	te		c. Location -		
	permit. Pages Department of Importent: If I eny injury or once.		*4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service		MEN	ORAH G				1/21/ FRC N			ROCKVI CHAPE		MARYLAND
ñ	Per E and		23a. Part. Enter the disease, or	I for	anused the dee	1	170	ROCKV	ILLE P	PIKE.	ROC	KVII	LLE. M	-	
	Physician		Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.			de or dyllig	, sucil as ca	ardiac or	respiratory	y allest,			Interval Between Onset and Death YEARS
8/60,	death certificate be executed  e attending physician and ed for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consection as a conse	quence of):									
O. Box 6	ne death certifi the attending I hed tor use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregn birth 2 Peta nant at time of c	aldeath 3	Ectopic p	pregnancy pecify)				_	23d. Date Mor	e of delive	ory Day Year
as, r	8 5 9		Part II. Other significant condition	ns contributing to c	death but not res	sulting in the u	nderlying	cause give	n in Part I.			d tobac	_		ne cause of death?
аі несога	The law ate has b page 2 sl	Completed									24a. Wi au pe 1 🗆 Yes	topsy rformed	17 8	Vere autoprior to con leath?	psy findings available npletion of cause of 2 \( \square\$ No
V 153	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of						
on or	ng Phy tter this ineral d	lon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin	28a. Date		28b. Time of Injury		28c. Injury Work	4   Nursii	28			e 6 □Othe		/)
UIVISION	ne Hospital or Attending 124 hours atter death. 16 Funeral Director: Atte bietely titled in by the tune	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place	e of Injury - At h ling, etc. (Speci				63 2 110		f. Location City or 1			er or Rura	I Route Number,
	Hospits     24 hours     Funeral     etely tilled	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the band man	e best of my kno basis of examina nner stated.	owledge, deatl ation and/or in	occurred vestigation	d at the time	e, date and p inion, death (	place, an	d due to th I at the tim	ne caus e, date	e(s) and mar and place, a	nner as st and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	- 5	)	5	29	c. License					Date signed		
)	15		30. Name and address of person	who completed carr	sa of death (the	m 23a) /Tune	Print)	D08	3944			JAN	WARY	20, 2	2004
			MARTIN C. SHARG	EL, M.D.,	3720 F	'ARRAGU'	,	ENUE,	KENSI	NGTO	N, M	D 2	0895		
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	ature	100	and I							

,	1	For State Registrar	Otato or mar		rtificate of		fental Hygi Re	g. No. 20	04	038	38
		. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month		Year	3. Time of C	eath
Physician		Bessi	e Marie Giv	ens			January		04	1135	A M
/Medical Examiner	_	a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County o	f Death		
LXummer		Union Hospital			Elktor	1		Ceci	1		
Funeral		. Social Security Number 6. Se		In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB 18,	Year)	9. Birthpla	ce (State or	Foreign
Director		216-30-8110	□M 2ĎF 85	Yrs.	Working	110010	FEB 18,	1918		land	
9	-	Jsual Residence of Decedent		0-07-7					100	d. Inside City	Limite
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar count be notified at once.  To Re Completed by Funeral Director		0a. State 10b. County	1	0c. City, Town or L	ocation				100	1 ⊠Yes	
vith the Mar t or 28a-f s	3	Maryland Cecil		Elkton							
or 28		Oe. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Countr	y?	
th w		216 East High St			21921			United			
al, or items 23s		1. Marital Status	12. Was Decedent Even Armed Forces?	er in U.S. 13.	Was Decedent of If Yes, specity Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	<ul> <li>Americal</li> <li>White, et</li> </ul>	n Indian, c.	
or ft		1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:		,	
urat;	2	3 ☑ Widowed 4 ☐ Divorced						0.10.10	Bla		
ed within 72 hor ygjene. ner than "natura nt, the Madical E	2	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	kind of work done	ipation a during most of work ad)	ang	16b. Kind of Bus Vetera		stry	
Athin he had	2	Elementary/Secondary (0-12)	College (1-4or 5+)				}	Admini		ion	
lygie lygie lygie lygie lygie lygie lygie	3 -	11 17. Father's Name (First, Middle, Last)		D16	etary Aid		e (First, Middle, N				
tal H doth	5						_	alderi Carrianie	*/		
Men Men Merke	2	William D. Wilso		10 14		Lucy An		City or Town	State 7in (	Parda)	
2 sh and Is m	- 1	19a. Informant's Name/Relationship (								,oae)	
and ealth m 27 her t	9-	Oliver G. Givens	, Sr./Son	9 Che 20b. Place of Disp		cive, Elkt		Tand ZI 20c. Location - 0		m State	
M ite	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Remoyal from State	Bohemia	matory or other pla Manor	ace)   Febr	uary	Chesape			
ury c		* 4 □Donation _5 □ Other (Specifi	) /	Cemetery		5, 2		Marylan	d		
port port y inj		21. Signature of Funeral Service Lice	≸6e /	$H^2$	2. Name and Addr LCKS HOME	ress of Facility for Fune	rals, P.	Α.			
89 5 9		In A Le	ach	110	03 W. Sto	ockton Str	eet, Elk	ton, Ma			21
7	1	23a. Part 1. Euler the disease, or com shock, a heart failure. List only	ation that caused the	e death. Do not er	ter the mode of dy	ing, such as cardiac	or respiratory arre	est,	1	Approximate nterval Betw	een
Physician	1	Immediate Cause (Final disease or condition	Cooks	e one	1				,	Onset and D	aun
/Medical	1	resulting in death)	Due to (or as a	consequence of):							
Examiner			Head	follow	e					_	
	<u>5</u>	Sequentially list conditions, if any, leading to immediate causs. Error underlying Cause (Disease or injury	Due to (or as a	consequence of):							
ician and burial-transit	Cyalillie	Cause (Disease or injury that initiated events	Heor	+ atto	rok						
ysician and e burial-transit	L Y	resulting in death) Last	Due to (or as a	consequence of):							
sicia a bur	2		d CAI	<u> </u>							
as th							155	-1			
attending physical for use as the t	Physiciatymedi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date	of deliver	/	
d for	2	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 4 Pregnant at tir		□Ectopic pregnan □ Other (specify)	cy		Mon	th C	Day Y	ar
y the	2	9 Unknown	9□ Unknown								
signed by the a	<u>.</u>	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contri	bute to the	cause of de	ath?
sign ld be	a by	(olitis					1 ☐ Ye	s 2 No	Proba	biy 4 □U	known
been si should t	ele	Diobetes	MellAu	5			24a. Was ar	24b. W	/ere autop:	sy findings a	vailable
has je 2	Completed	pioceies	Vite III)				autops	y pr ged? de	rior to com eath?	pletion of ca	use of
certificate has rector, page 2					-				☐ Yes 2	!□ No	
icien sertifi ector	De	25. Was case referred to medical examiner?	Hospital:			ther	th Check only one				
	9	1 ☐ Yes 2 No		2 ER/Outpatie	ef 3 DOA	4 U Nursing H	ome 5 Reside 28d. Describe ho				
this ald		27. Manner of Death	28a. Date of Injury (Month, Day)		W		20d. Describe 110	w injury occurre	, ,		
Ing Phys		1 Natural 5 Pending	n			□Yes 2□No	206 1		and District	Clause Alcomb	
landing Physeath.  or: After this the funeral di		2 ☐ Accident investigatio	0		treet, factory, office	9	28f. Location (Sti City or Town	reet and ivumbe i, State)	or or Hurai	HOULE INUINL	ω,
or Attanding Physics death. irector: After this a by the funeral distriction.				(Specify)			,				
or Attanding ther death. Director: After in by the fune	Certification;	2 Accident Investigatio 3 Suicide 6 Could not be determined	building, etc.	(Specify)							
or Attanding ifter death. Director: After in by the fune	Certification;	Z Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  Check only	building, etc.  nysician: To the best of niner: On the basis of e	(Specify) my knowledge, dea examination and/or i			, and due to the ca				
tter death. Director: After in by the fune	edical Certification:	29a. Certifier (Check only one)	building, etc.  hysician: To the best of miner: On the basis of eand manner state	(Specify) my knowledge, dea xamination and/or i	nvestigation, in my	opinion, death occu	, and due to the ca	ate and place, a	nd due to t	the cause(s)	
the Hospital or Attanding in 24 hours after death. The Funaral Director: After pletely filled in by the fune	edical Certification:	29a. Certifier (Check only one)	building, etc.  hysician: To the best of miner: On the basis of eand manner state	(Specify) my knowledge, dea xamination and/or i	nvestigation, in my	opinion, death occu	, and due to the ca	ate and place, a	nd due to t	the cause(s)	
or Attanding fler death. Director: After in by the fune	edical Certification:	29a. Certifier (Check only one)	building, etc.  hysician: To the best of miner: On the basis of eand manner state	(Specify) my knowledge, dea xamination and/or i	nvestigation, in my	opinion, death occu	, and due to the ca	ate and place, a	nd due to t	the cause(s)	
or Attanding Physiter death.  Director: After this in by the funeral di	edical Certification:	Z Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  Condition investigatio 6 Could not be determined	building, etc.  hysician: To the best of miner: On the basis of eand manner state	(Specify) my knowledge, dea xamination and/or i	nvestigation, in my	opinion, death occu	, and due to the ca	ate and place, a	nd due to t	the cause(s)	

Physician /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 end any injury or other traumatic event, Ita Medical Everning must be notified at 1006s.

Enysician /Medical Examiner

Baltimore, Maryland 21215-0036

įro	dell Ginn Please Ty	/pe or Print in Black In	delible Ink. Ensure Al	l Copies Aı	re Legible.	
ęŝ	1 - For State Unpend Item #23a,	State of Maryland / Depa pt.II,27 per me G828021	artment of Health and M	lental Hygie	2004	03839
an al	1. Decedent's Name (First, Middle, Last)  LAW RENCE V	lardell (Tino		2. Date of Death Month February	°0′1, 2ď0′4	3. Time of Death 2015 P M
er	4e. Fecility Name (If not institution, give st.	reet and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
	207 Laurel Street	Apartment C	Pocompke		Worcester	
	5. Social Security Number 327 - 34 - 446  Usuel Residence of Decedent	M 2□F 7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	gar Coun	lace (State or Foreign try)
<u>.</u>	10a. State 10b. County	10c City Town or Lo	- L -		1	0d. Inside City Limits 1
ecto	1 (12	SIEK YOCON		10-	0:4:	
ă	10e. Street and Number	1 ~ C	10f. Zip Code	10g.	Citizen of What Coun	try?
rai	901 rancel 31	API.C	1/00/01/01/01/01/01		14. Race - Americ	an Indian
by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? I	Was Decedent of Hispanic Origin? (Spo f Yes, specify Cuban, Mexican, Puerto f □ Yes 2≰No Specify:	Rican, etc.)	Black, White,	
Be Completed by	15. Decedent's Educa (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	16l	b. Kind of Business/Ind	dustry
Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	-aborer	1	outry 1	ndustry
To Be (	17. Father's Name (First, Middle, Last)  NUMBER M: 1 bo	urne	18. Mother's Name	First, Middle, Mai	and	0
1	BERNICE G. Holland	9, <i>Print</i> ) 19b. Mailir 1- Mother 809	and Si. To come		ity or Town, State, Zip	Code)
	20a. Method of Disposition 1. ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State 20b. Place of Dispo	sition (Name of natory or other place)	Date 200	Location - City or To	wn, Stete
	* 4 □ Donation 5 □ Other (Specify)	DohnsNed		(-4 ) }	ocomoke	MD
	21. Signature of Funeral Service Licenses	5.	Name and Address of Facility  No. 1	Euneral H	Anne Mi	21853
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one		er the mode of dying, such as cardiac of	or respiratory arrest.		Approximate Interval Between
	Immediate Cause (Final disease or condition	Arteriosclerotic car	diovascular disease			Onset and Death
	resulting in death)	Due to (or as a consequence of):	and tables and an another			
	Sequentially list conditions, b.					
miner	if any, leading to immediate	Due to (or es a consequence of):				
	Cause (Disease or injury that initiated events resulting in death) Last					
cal Ex	d.	Due to (or as a consequence of):				
Med	IF FEMALE:					3.5
Completed by Physician/Medical Exa	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
y Ph	Part II. Other significant conditions cont	ributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
edk	Diabetes mellitus			1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
complet				24a. Was an autopsy performed Yes 2	prior to cor death?	osy findings available inpletion of cause of 2 No
Bec	25. Was case referred to medical examiner?		26. Place of Death		/\	
2	1 XYes 2 No	spital: 1   Inpatient 2   ER/Outpatien			e XX Other (Specify	At scene
00	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work?	28d. Describe how i	injury occurred	
rtificati	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Stree City or Town, S	it and Number or Rura State)	Route Number,
Medical Certification:		cian: To the best of my knowledge, death ar: On the basis of examination and/or in and manner stated.				
Me	29b. Signature and tale of certifier		29c. License number	29d.	Date signed (Month, I	Dav. Year)

To the Hospital or Attending Physician: The law recuires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 sho At be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this

29b. Sign

O.C.M.E.

29c. License number 29d. Date signed (Month, Day, Year)

30. N eted cause of death (Item 23a) (Type, Print) February 02, 2004

LARen 31. Date filed (Month, Day, Year)

Day, Year)

See Description of 2004

See Descr 111 Penn Street, Baltimore, Maryland 21201

State Registrar

			1 - For State Registrar	State of M	laryland /		rtment tificate			ind M			2004	03840
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	cal	Martha E.  4a. Facility Name (If not institution, give s		r)		4b. City. T	Town, or	Location o		<u>January</u>		2004 ounty of Death	8:00 A <sup>M</sup>
1	Examir	ier	Manor Care Healt				10. O.ly,		ilver		ing		•	
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. last		If Under		If Under		8. Date of Birti (Month, Da)	Reg. No.  Death Day Year TY 18 2004  4c. County of Dea Mont Birth Day, Year) 19, 1916 V  10g. Citizen of What C United No- 14. Race - Am Black, WA Specify: A  16b. Kind of Business NSA — dle, Maiden Sumame) ttie Jackson mber, City or Town, State, lenn Dale, M 20c. Location - City or Suitland t Funeral Ho Wash., DC y arrest,  23d. Date of de Month  23d. Date of de Month  23d. Date of de Month  (y one) esidence 6 Other (Spector) be how injury occurred  (Street and Number or Formary, State)  1 year  29d. Date signed (Month)	place (State or Foreign	
	Director		577-30-0753	M 2□ <b>X</b> F	87	Yrs.								rginia
pue	ž ==		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation						T	10d. Inside City Limits
Mar	8 2	호	Maryland Prince G	George's			G1e	nn l	Dale					1 X Yes 2 ☐ No
5-0056 72 hours after death with the Maryland	or 28e	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
4	23a	ral	11408 Prospect						207					
ar de	tems	nne	11. Marital Otatas	12. Was Deceden Armed Forces	?	13. V	Vas Decede Yes, speci	ent of Hi ify Cubai	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, Waite	can Indian, rafican
ZIZIO-CIZIZ	, i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	-	1	☐ Yes 2	No X	Specify:			Sp		erican
֓֞֓֓֓֓֓֓֟֓֓֓֟֓֓֓֟֓֓֓֟֓֓֟֓֓֓֟֓֓֓֟֓֓֓֟֓֓֓	ature Scal E	ted	15. Decedent's Edu	cation			lent's Usual			of working		16b. Kind	of Business/Ir	ndustry
		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	kind of worl OO NOT use A	e retired,	)	OI WOIKII	ig	N	CA C	
7	Il Hygiene. other than vent, the Ma	S		22				nal		1.41-	/5: 16:1#L			overnment
Maryland	even	Be	17. Father's Name (First, Middle, Last)	D					18. Mothe	rs Name				
r y	f Health and Mental Hygiene. Item 23s or 28e-f show then 27s or 28e-f show other traumatic event, the Modical Examitment cannot be notified at	ပ	19a. Informant's Name/Relationship (Ty	Bowman	1	19b. Mailin	a Address	(Street a	nd Numbe	r or Rura				p Code)
בריים בריים	Ith an 27 is r trau		Janet Braxton - I	•								-		20769
15 "	f Health item 27 other tra		20a. Method of Disposition		come	of Dispo	sition (Nam	e of	1	-	ate			own, State
altimore,	int: If		1. Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	θ	-	-			1/23	/2004	Sui	tland.	MD
2 2	Department of the Important: If ite any injury or of once.		21. Signal re of Funeral Service Licens	• A	-		. Name and							
0 8	40 E # 9		23a. Part1. Enter the disease, or compli	RUSANX	111	-							, DC	20019 Approximate
/ E	hysician by wasician and hysician and hysician stransit ithe private transit ithe private transit in the private t	i Examiner	shock of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a		es of):	ia							Interval Between Onset and Death
P.O. DOX 6	igned by the attending physics detached for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	4□Pregnant 9□Unknown	2 Fetal death	ath 3 ☐	Ectopic pre	ecify)	on in Part I.		23e. Did to		Month	Day Year
ő	been sig										1 🗆 Y	es 2 🗆 N	lo 3□Prol	babiy 4 ⊡Unknown
		Completed									24a. Was autop perfor 1 ☐ Yes	sv	prior to co	opsy findings available ompletion of cause of 2 No
or vita	certifica ector, p	Be	25. Was case referred to medical examiner?	lospital:				Othe	100		(Check only o			
	Affe	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, £	jury 28	Outpatien b. Time of Injury		Bc. Injury Work	417 90	2				fy)
UIVISION	s after death. Is after death. Is Director: Afte	Certification;	3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At home etc. <i>(Specify)</i>	, farm, str	eet, factory,	, office		2			lumber or Run	al Route Number,
2	within 24 hours after of To the Funerel Directory completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the bes ner: On the basis and manner:	of examination	dge, death and/or inv	occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	nd due to the o	ause(s) and pla	d manner as s ace, and due t	stated. to the cause(s)
, ,	within 2  To the complet	Me	29b. Signature and title of certifier	- (	Α Α	10	29c.	License	number	1				
			) / XUIL		) [[	ID		D		79"			say!	20,2000
R	(4)		30. Name and a ress of person who co	TIMORI	= ++1	eni	Print) La	lith	a Tac	dikor	nda, M.	D. 20	707	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 2 2004	32. Regis	strar's Signature	hour	2							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JANUARY 13. 2004 11:50P EMILY BORTON GARNER /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** MARINER HEALTH OF GREATER LAUREL PRINCE GEORGES LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M XXF Days 10, 1915 NEW JERSEY 88 Director 220 34 2759 Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at XX Yes 2 No Directo MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20743 UNITED STATES "naturel", or items 23a 204 SHADY GLEN DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "naturel", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE þ XX Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 4TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNA ADAMS ဂ္ BENJAMIN L. CAMP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 454 AUDREYS LANE LOUISA. VA 23093 ELIZA DONOVAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Importent: If Iter
eny injury or oth METROPOLITAN CREMATORY 01/15/04 \* 4 □ Donation 5 □ Other (Specify) ALEXANDRIA, VA of Fureral Service Licenses 21. Signalur MARSHALL S FUNERAL HOME OF MARYLAND, INC. lawal 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MANY YEARS Physician a. HYPERTENSIVE CARDIOVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 23181 1-15-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GORMAN AVE#TH. LAUREL, MD 2070 704 · G-BHOJRAJ.M.D 31. Date filed (Month, Day, State JAN 2 1 2004 Registrar

		4	For State Registrar	State of	Marylar	nd / Depa <i>Cer</i>	rtment of H	ealth a Death	nd M		giene Reg. No.		) 4	03842
	Physici	an	1. Decedent's Name (First, Middle, La Eva E. (	•					1	2. Date of Dea Month anuary	ath Day 20	26	004	3. Time of Death $12:25A  M$
	/Medic		4a. Facility Name (If not institution, gi		nber)	-	4b. City, Town, or	Location of	1	anuary		County of		12.2JA ""
	LXdillii	CI	Southern Maryland				Clintor	1			P	rince	Ge	orge
6	Funeral Director		411-48-3728	Sex 1 □ M 21€ F	7. Age ( <i>In yr</i> s. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Sept. 2	/ Year	1912	Birthp Coun Cenn	lace (State or Foreign try) .essee
	fand ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	Mary 9-f sh	tor	Maryland Prince	George	Fo	restvil	lle							1⊈Yes 2☐No
	or 28.	Directo	10e. Street and Number				10f. Zip Code				10g. Citi	zen of Wh	at Coun	try?
	s 23a		7420 Marlboro Pi	ke 12. Was Dece	dost Ever in I	10 12 1	20747		:=2 (C==	- West Version No.		ited		
350	be filed within 72 hours after death with the Maryland ital Hyglene.  dother than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed For 1 Yes If Yes, Giv	rces? 2∰No e	11	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2점 No	spanic Origin, Mexican, Specify:	Puerto f	city Yes or No- Rican, etc.)		Black,	White,	etc.
9500-91212	72 hou	Completed	15. Decedent's E (Specify only highest gi			(Give	ent's Usual Occupe	lurina most i	of working	10	16b. Ki	nd of Busin	ness/Ind	dustry
7	Mithin han	mple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. D	onemaker	)			D <sub>1</sub>	civat	Δ	
7	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Las	1)		110	memaker	18. Mother	's Name	(First, Middle,				
<u> a</u>	uld be Aental rked o	To Be	Samuel Pierce					Racl	hel :	Dykes				
Maryland	s 1 and 2 should be filed w f Health and Mental Hygiei item 27 is marked other ti other traumatic event, In		19a. Informant's Name/Relationship				g Address (Street a							
	and ealth m 27		Anna Coley/Dau  20a. Method of Disposition	ghter	20h I		I. Hampto		16.3	on Park		Lorid cation - Cit		33825
פֿב	Pages nent of P nnt: If ite		1 ☑ Burial 2 ☐ Cremation 3 [  '4 ☐ Donation 5 ☐ Other (Special Control of Co		SIALU L		sition (Name of patory or other place n Nationa			6, 2004		uitla	•	
	permit. Pages 1 Department of H Importent: If ite eny injury or ott		21. Signature of Funeral Service Lice		01.0	-1	Name and Addres			pe Fune 38 Marl restvil				
	66202		Wa Satt Starte dies	1/1	aeci	th. Do not onto	ur the mode of drive	- auch an a	Fo	restvil	le,	MD.	207	
	e - 5		23a. Part1. Enter the discussion, or conshock, or heart fail. List only Immediate Cause (Final	one cause on e	ach line.	tn. Do not ente	er the mode of dying	g, such as c	ardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (	or as a consec	uence of):	MIA						+	
	Examiner		Sequentially list conditions	b	SAN	GRE	NE							
	ed isit	lner	Sequentially list conditions, if any, leading to immediate	1 7000000000000000000000000000000000000	or as a consec					2			1/4	
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	I PIJG	n A L quence of):	VASCU	LAR		) I S Ex	15 E		-	······································
8/6U	ysicial	dical		_ d										
		0	IF FEMALE:			30740-				350	1			
O. Box	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 Peta ant at time of c	al death 3 🗌	Ectopic pregnancy Other (specify)				2	23d. Date o Month		ry Day Year
Ţ.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the un	derlying cause give	n in Part I.		23e. Did to	bacco u	se contribu	ite to th	e cause of death?
rds	w requires been sign should be									1 🗆 Y	es 2[	□No 3{	Prob	ably 4 🖽 Tiknown
Vital Records,	e law re has bee	Completed								24a. Was a autop perfor	sv	24b. Wei prio dea	r to con	osy findings available appletion of cause of
<u>e</u>	sician: The law certificate has t irector, page 2 s	e Co	25. Was case referred to medical					00 Disease	-4 D +	1 Yes	2 1 No			2 No
	Physician: r this certific ral director,	0 0	examiner?	Hospital:	patient 2	ER/Outpatient	3□ DOA Othe			(Check only or ie 5 ☐ Resid		i∏Other /	Specify	)
0	ng Physic Iter this of neral dir	n; T	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of		28b. Time of	28c. Injury Work	at		8d. Describe h				
<u>S</u>	Attending ir death. ector: After by the fune	icatl	2 Accident investigation 3 Suicide 6 Could not l		-41-i A.S.			res 2□N	-	04			. 0	Control Manager
=	or Attending Fatter death.  Director: Alter din by the funera	Certification;	4 Homicide determined	289. Place	of Injury - At n ig, etc. <i>(Speci</i> i		et, factory, office		2	City or Tow			or Hural	Route Number,
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the miner: On the ba and mann	isis of examina	owledge, death ation and/or inv	occurred at the timestigation, in my op	e, date and inion, death	place, a	nd due to the o	ause(s) late and	and manne place, and	er as sta	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				29c. License			2	9d. Date	signed (A	Aonth, L	Day, Year)
	6		> Sherif t	fun.	MD		D50	862			200	UAL	1,2	0,2004
	4)		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type, F	31 CORC	enh	0.1+	Rd #	03	Loud	17111	0, 2004 MD20706
	Sta	te	31. Date filed (Month, Day, Year)  JAN 2 1 2004	32. Re	egistrar's Signa	ature				1,001/		-LINE	WHY K	1

			1 - For State of Ma	ryland / Depa <i>Cer</i>	rtment of F		Re	g. No. 2004	03843
	Physicia /Medic		Decedent's Name (First, Middle, Last)     Maria Cect	llia Mata-	De Gaita	n	2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Fecility Name (If not institution, give street and number) Washington Adventist H	-	T akoma			4c. County of Death Montgon	nery
(te	Funeral Director		5. Social Security Number  N/A  6. Sex  1  M 2  F  7. Age  Visual Residence of Decedent	(In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 22,	Year) 9. Birth Col.	place (State or Foreign intry) Salvador
	Maryland s-f show	tor		10c. City, Town or Lo		ttsville			10d. Inside City Limits 1 🐴 es 2 ☐ No
	er death with the Marylan Rems 23e or 28e-f show er mest be notified at	al Director	10e. Street and Number 8125 14th Avenue		10f. Zip Code	20783	10	g. Citizen of What Cou El Salvad	
036	를 무용하다	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E-Armed Forces?  1 Yes, 2X No. If Yes, Give Year or Dates:			dispanic Origin? (Spean, Mexican, Puerto Specify: El S		14. Race - Amer Black, White Lan <sub>Specify:</sub> Whi	, etc.
21215-0036	d within 72 piene. r then "nai	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	lent's Usual Occup kind of work done DO NOT use retired Homema	during most of work	ing	6b. Kind of Business/le Privat	
Maryland ?	uld be filed Mental Hygid Irked other stic event, II	To Be C	17. Father's Name (First, Middle, Last) Arcadio Melara Martinez			18. Mother's Name Mai	(First, Middle, Mi ria Leand		
	s 1 and 2 should if Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print)  Jose Gaitan-Mata (Son)	8125	14th Ave	enue, Hyat	ttsville,	City or Town, State, Zi	
Baltimore,	Pages 1 nent of H ant: If ite ury or otl		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposementary, crem	o General	1/30,	/2004 E	Jaquillisco, Laquillisco, El Salvador	1
Bal	Departr Imports eny inji		21. Signatural f Funeral Service Licentage (Control of Signatural ervice Licentage (Control of Signatura Service Control of Signatura Service Control of Signatura Service (Control of Signatura Service Control of Signatura Service Control of Signatura Service (Co	91	013 Annar	polis Road	d, Lanham	Funeral F n MD 20706	Iome Approximate
	/Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause in the cause in the cause (Disease or injury that infliated events	consequence of):	on_		-mfil		Interval Between Onset and Death
.O. Box 68760,	death certificate e attending phy d for use as the	Physician/Medical E	d	f pregnancy	Ectopic pregnancy	,		23d. Date of deliv Month	very Day Year
ords, P	The law requires that the tite has been signed by thoage 2 should be detache	by	Part II. Other significant conditions contributing to death but  Description	not resulting in the un	1	en in Part I.		cco use contribute to	the cause of death?
Vital Records,		Be Completed	Michael Groundate  Nucleolic acidos  25. Was case referred to medical acidos	on an	d hea	26. Place of Death	24a. Was an autopsy performe	ed? prior to co death? 1 Yes	opsy findings available ompletion of cause of
oţ	ing Phys After this uneral dir	P	examiner?  1 Yes 2 No Hospital: Impatien  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injur Wor	er: 4 Nursing Ho		ce 6 Other (Speci	( <b>h</b> )
Division	ial or Attendi s after death. al Director: A ed in by the fu	Certification:	C C Could see be	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	xamination and/or inv	restigation, in my o	pinion, death occurr	ed at the time, dat	e and place, and due t	to the cause(s)
0	To viti	W	29b. Signature and title of certifier	tomo	29c. Licens	953	290	d. Date signed (Month,	Lay, Year)
	(3)		30. Name and address of person who completed cause of de	#207		anna	0 mg	white	
	Sta Registi		JAN 2 2 2004	& Coal	ريخ				

DHMH 17 Rev 1/2001

ORIGINAL

		T - For Stote Registrer	State of Ma	arylan	_	artmen rtificate					giene 2 Reg. No.	004	03	841
		1. Decedent's Name (First, Middle, Last	)							2. Date of De		V	3. Time o	of Death
Physic		DOLUCII	ea Anne	Hri	ndac					Month Januar	Day y 20, 2	Yeer 2004	6:05	A M
. /Med Exam		A - Francisco Manage (Manage Inc. Manage Inc. Alberta Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.	street and number)		-	4b. City,	Town, or	Location of				nty of Death		
Exam	mer	Holy Cross Hospit				Si	1ver	Spri	ino		Mont	gome	cv	
		5. Social Security Number 6. Se		e (In yrs. I	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birth	place (State	or Foreign
Funera Directo			7	3	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sep <b>tem</b> be	r 4, 1930	New	Jerse	У
		Usual Residence of Decedent												
/lanc	1	10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside (	•
Mar	ţ	Maryland   Montgome	ery	В	ethesd	la							1	s 2 No
the 28a	Je C	10e. Street and Number		L		10f. Zip	Code				10g. Citizen	of What Co	untry?	
3a o		8005 Park Lane				20	814				United	1 Stat	tes	
Jeat Tis 2	9	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Deced	dent of Hi	spanic Ori	igin? (Spe	cify Yes or No	- 14. F	ace - Ame	ncan Indian,	
fer fer	Funeral Director	1 ☐ Never Mamed 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ ?	No	1	1 ☐ Yes	101			Rican, etc.)		llack, White	, etc.	
urs a	À		If Yes, Give Year or Dates:		-	1 🗆 105	2 <u>6</u> 1 NO	зреспу.			Spe	cny: W	hite	
ified within 72 hours after death with the Maryland Hygiene. Hygiene, sther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation		16a. Dece	dent's Usua	al Occupa	ation	t of worki	na	16b. Kind of	Business/	ndustry	
Med .	19	Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of wo DO NOT us		)		•				
gien die	Š	12			Hom	emake	r					Home		
S at Ho	B							18. Mothe	er's Name	(First, Middle	, Maiden Surr	ame)		
wid by Ments	F	James Frawley						C	harl	otte So	cott_			
s me		19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ing Address	(Street a	and Numbe	er or Rura	I Route Numb	er, City or To	vn, State, Z	ip Code)	
and 2		William G. Hrinda	c /Husban						theso	la, Mar				
partition of a ward should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat mast he notified at		20a. Method of Disposition	Damawal from State	20b. P	lace of Disperent	osition (Nar matory or o	me of other plac	e) .	Janua	ry 24,	20c. Locatio	n - City or	Town, State	
Page Int.	0	1 🎇 Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify			e of He				2004		Silver	Spring	, Maryl	and
mit.		21. Signature of Funeral Service Licen-	500 /		D.2	2. Name ar	nd Addres	s of Facili	ity The most	rol Homo	/Potheod	a Charr	r Chana	Tno
P P P P P	ğ	Umrelate Burner	fo	MO13	305 75	557 Wis	sconsi	ipiirey in Ave	nue,	ral Home Bethesda	, Maryla	a-chev ind 208	14–3501	, шс.
		23a. Party. Enter the disease, or comp	leations that caused	the deat									Approxima Interval Be	ate
747-11		shock, or heart failure. List only of Immediate Cause (Final			TT	17-41						13	Onset and	
Pnysicia /Medica		disease or condition resulting in death)	a. Conges  Due to (or as			rail	ure							
Examine	•		Chroni			ilure								
	<b>1</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as			LIGIC								
nsit	- 5	cause. Enter Underlying Cause (Disease or injury	Pneumo	nia										
be executed ician and burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):									
e be e	led		Chroni	c Ob	struct	ive P	ulmo	nary	Dise	ase				
ECOLUS, F.O. BOX 60100, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	1	3	<u> </u>											
ox or certiing and ing use a	100	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d.	Date of del	,	
atter 1 for	M/acioloud0	in the past 12 months?	1 □Live birth 4□Pregnant a			□Ectopic p □ Other (st						Month	Day	Year
the d	1	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown											
that deta			ontributing to death b	ut not res	ulting in the	underlying o	cause giv	en in Part I	l.	23e. Did	tobacco use c	ontribute to	the cause of	f death?
w requires been signed should be	1									10	Yes 2□No	3 X Pr	obably 4	_Unknown
v req beer shou	3									24a. Was	an 24	b. Were au	topsy finding	s available
2 as a co	To de la casa									auto	ormed2	death?	topsy finding completion of	cause of
ysicien: The lavis certificate has										1 Yes	25 No	1 ∐ Yes	2 No	
VICAL icien: 1 certifical ector, p	0		Hospital:				OA Oth	ar		(Check only		011 10	- 6.1	
this aldi	F		Inpati		ER/Outpatie		02			me 5 ☐ Res 28d. Describe			ciry)	
After funer	1	1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	28c. Injur Wor	k? Yes 2□			, ,			
DIVISION OF VITA  To Attending Physicien: after death. Director: After this certification by the funeral director,		27. Manner of Deam  1 Natural 2 Accident investigation 3 Suicide 6 Could not be determined		iury - Ath	ome farm s					28f. Location	Street and Nu	imber or Ru	ıral Route Nu	ımber,
or A or A or A or A or A or A or A or A		4 ☐ Homicide determined	building, e	c. (Specif	fy)		,,				wn, State)			
UIVISION OF  To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral			ysicien: To the best	of my kny	owledne dea	th occurred	at the tir	ne, date ar	nd place.	and due to the	cause(s) and	manner as	stated.	
Hos 24 ho Fun		29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exen	niner: On the basis of and manner st	of examina	ation and/or i	nvestigation	n, in my o	pinion, dea	ath occurr	ed at the time	, date and pla	ce, and due	to the cause	)(s)
To the Hos within 24 h To the Fur completely		29b. Signature and title of certifier				29	c. Licens	e number			29d. Date sig	ned (Mont	h, Day, Year)	1
		1500000	Cha	000	ali	ת	0005	8968			Januar	v 20	2004	
6		Juarve	nomelated at	de este //	- 02	_						, _0	,	
		30. Name and address of person who			1		D.	obset 1	114	Marria	nd 200	52		
		Saima Khawaja, M	32. Regist			rike	, KO	CKATI	LIE,	Maryla:	uu 2001	1 4		
Regi	State istra	1841 0 0 000		June de	G	100	uks	/						

		1 - For State Registrar	State of Marylan			of Health and <i>of Death</i>		giene Reg. No.	CUU4	03845
		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	/ Yeer	3. Time of Death
Physic /Medi		Christine P. Howa	ard				January	y 16	, 2004	12:45A M
Exami		4a. Facility Name (If not institution, give st	reet and number)		4b. City, To	wn, or Location of Dea	ath	4c.	County of Death	1
		Rockville Nursing				ville			ontgome	
Funeral		5. Social Security Number 6. Sex 1 1	7. Age ( <i>In yrs</i> . 89	last birthday) Yrs.	If Under 1 \ Months E	Year If Under 24 H Days Hours Mi		h y, Year)	9. Birth	place (State or Foreign intry)
Director		Usual Residence of Decedent	- 09	113.			Dec. 25,	191	4 Mary	Land
yland ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Man, Heth	to	Maryland Montgomer	y G	aither	sburg					1 ☐ Yes 2 ☑ No
h the	Director	10e. Street and Number			10f. Zip Co	ode		10g. Citi	izen of What Col	intry?
23a c	a D	1010 Quince Orchard	d Road		2	0878		Un	ited St	ates
r dea	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	.S. 13.	Was Decedent If Yes, specify	it of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		<ol> <li>Race - Amer Black, White</li> </ol>	
s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2X	No Specify:		-	Specify: Wh:	ita
hour tural'	ed b	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a Decer	dent's Usual (	Occupation		16h Ki	ind of Business/l	
in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work of DO NOT use	done during most of w retired)	rorking			nstitutes
iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Lab	orator	y Technici	Lan		of Heal	th
e fite I Hyg othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden	Sumame)	
Alenta Alenta rked tic ev	TO B	Sidney S. Connell				Hattie	Violett			
2 sho and h	į,	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (S	Street and Number or	Rural Route Numbe	er, City o	r Town, State, Z	ip Code)
and and and in 27		Ronald L. Federline				Drive, Ij				
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f ehow entry injury or other traumatic event, the Medical Examiner near the multipol at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State   Dar	Place of Dispo	natory or other		uary 20,	20c. Lo	ocation - City or 1	own, State
Pages tment of tent: If it		' 4 ☐ Donation 5 ☐ Other (Specify)	Chu	rch Ce	meterv					Maryland /
ermit Depar npor ny in		21. Signature of Funeral Sovine License		Ro	Name and Ackvill	e, Inc. 30 kville, Ma	00 West Mo	rump ontg	nrey rui omerv Av	neral Home/ Zenue.
4 40240			M0068						<del>-</del> 2805	Approximate
		23a. Part Enter the disease, or complic shock of heart-failure. List only on Immediate Cause (Final	e cause on each line.	n. Do not on	or the mode c	or dying, addires our di	as or roophatory as	1001,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Bilateral		nia	<u> </u>				
Examiner			Due to (or as a conseq Gastrointe		Rlood	ina				
St.	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq		preed	TIIg				
cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Respirator	y Fail	ure					
rate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
ate be ex hysician the burial	dical	d								
ntifica ing pt	Med	IF FEMALE:								
ath cer ttendin or use	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3	Ectopic preg			1	23d. Date of delift Month	very Day Year
the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath 5	Other (spec	ify)				,
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cau	se given in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?
he law requires t has been signe age 2 should be	d by				, ,		101	res 2	□No 3□Pro	bably 4 Dunknown
requ	Completed						24a. Was	20	24h Were aut	oney findings available
has ge 2	dw				<del></del>		- autop	sy rmed?	death?	opsy findings available ompletion of cause of
icien: The certificate ector, pa	e Co	25. Was case referred to medical				OC Place of P	1 Tes		1  Yes	2 No
sicie	00	eyaminer?	ospital:	ER/Outpatier	nt 3 DOA	Other	eath <i>(Check only o</i> Home 5☐ Resid		6 □Other (Spec	ifu)
a Phy er this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	28d. Describe h			,
e fun	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII, Day Teal)	Injury	М	1 Yes 2 No				
f or Attending after death. Diractor: After in by the fune	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti	reet, factory, o	office	28f. Location (S City or Tox	Street an vn. State	d Number or Ru	ral Route Number,
rs after all Die	Certification:									
To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2:	edical		ician. To the best of my known of the basis of examina							
the Phin 24 the P	Medi	one)	and manner stated.			icense number			te signed (Month	
Sor Cor	-	29b. Signature and title of certifier	21 Pin . A.					_54. Udi	ro aidilian (Moliff)	, way, (vai)
5	13	Nouns	V. Posiph			D47330	J	Tanua	ary 19,	2004
		30. Name and address of person who con				Danier - # 0	07 D		***	25050
2	ate	Thomas V. Joseph, 31. Date filed (Month, Day, Year)	32. Pegistrar's Signa			orive. # 2	U/ KOCKV	1110	, Mary1	400 40004
		IAN 2.0.200	11 Samuel	19	Ann.	11 1				

			1 - For State Registra/MEND#12perINF1/	State of Maryl	and / Depa		of Health a	and Mer		ene 3. No. 20	nl. na	81.6
			HegistraH*EIVD#1ZDEF1IVF1/     Decedent's Name (First, Middle, Last)	28/04, HMW, MOC	0 00,	timodio c	or Boatti	2.	Date of Death		3. Time of	Death
н	Physici	an	Dennis G. Hovis					G	Month TANUAL	Dey	Yeer 2007 5:2	7 PM
1	/Medic		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Tow	vn, or Location o		~	4c. County of		
	LXdiffiii	Ci	Union Memorial Ho	snital		Balti:	more					
	Funeral		5. Social Security Number 6. Sex	7. Age (In )	yrs. last birthday)	If Under 1 Y		24 Hrs. 8. Min.	Date of Birth (Month, Day, )	(ear)	9. Birthplace (State of	or Foreign
П	Director		579 <b>-</b> 56 <b>-</b> 5139	M 2□F 56	Yrs.	Months	ays Hours	Αι	ıg. 5,	1947	Wash. D.C	•
	P .		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	eation					10d. Inside C	ity Limits
	anyla shov	5			Baltimore						1 ☑ Yes	
	28a-1	Director	Maryland		Dal LIMOI	10f. Zip Coo	do		100	g. Citizen of W		
	with t	급	340 E. 28th Street			212						
	eath	Funeral		2 Was Decedent Ever i	in U.S. 13. \			ain? (Specify			States - American Indian,	
	ter d	Ē	M Never Married 2 Married	Amed Forces? 8_] 1 X Yes 2 □ No If Yes, Give	4-68		of Hispanic Orig Cuban, Mexican	, Puerto Rici	an, etc.)	Black	k, White, etc.	
936	urs a	þ	3 Widowed 4 Divorced	If Yes, Give	<del>n k•</del> -72	1☐Yes 2万	No Specify:			Specify:	White	
0	72 hours after death with the Maryland "natural", or itema 23a or 28a-f show idical Examiner, suit be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Or	ccupation lone during most etired)	t of working	16	6b. Kind of Bus	siness/Industry	
21	S - 2	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			etired)			o .		
2	T1 (7)	S	12		Carı	penter				Constru		
n	i be file ntal Hyg od othe : event,	Be	17. Father's Name (First, Middle, Last)						irst, Middle, Ma	aiden Sumame	9)	
∑ Sa		မ	Lester Hovis	8:4	405 14-75			ia Cho		Oh T (	Chan Zin Chada)	
Maryland 21215-0036			19a. Informant's Name/Relationship (Typ				Cod on the				state, zip code)	
dî.	1 and 2 Health tem 27 i		Amy Hovis (da 20a. Method of Disposition	ughter)	b. Place of Dispo	sition (Name o	Geiger	Date	The second second second	523 Dc. Location - (	City or Town, State	
Ö	nt of		1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State	Chesapea			1/23/	/04 B	oltevil	lle, Maryl	and
Baltimore,	ritania i		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Livense	2	_		ddress of Facility					and
Ba	permit. Pages 1 Department of H Important: If Ite any injury or of		1.1.1	15		_						20012
	_		23a. Part1. Enter the disease, or complic	ations that caused the d							Approximat	te
1	Dhusisian		shock, or heart failure. List only one Immediate Cause (Final			- 10	1 - 441	·- 04	740		Interval Bet Onset and	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):	C prc.	310 19	10811	//-/		4115	+ 77
8	Examiner			1446	resequence of):	ENSI	100				UNISTE	WW
		Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a con	sequence of):							
	te be executed ysician and se burial-transit	Examiner	that initiated events c.						<u>-</u>			
0,	be exe ician a burial-	Ä	resulting in death) Last	Due to (or as a con	isequence of):							
8760,	# × #	lcal	d.									
x 68	eath certific attending p	Physician/Med	IF FEMALE:	sc. If yes, outcome of pre	22222							
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ I 4 Pregnant at time	Fetal death 3	Ectopic pregn Other (specif				23d. Date Mon	of delivery oth Day '	Year
0.	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ordeath 5L	_ Other (specin	(y)					
<u>α</u>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it		Part II. Other significant conditions con	ributing to death but not	t resulting in the u	nderlying caus	se given in Part I.		23e. Did toba	icco use contri	bute to the cause of c	death?
Vital Records,	uires sign	d by							1 Tes	2. No	3 ☐ Probably 4 ☐	Unknown
Ö	w requir been s should	Completed							24a. Was an	24b. W	Vere autopsy findings	available
Re	The lav	E D							autopsy perform 1 Tes 2	ed? di	eath?	ause of
a			25. Was case referred to medical				26 Place	of Death (C	1 ☐ Yes 24 Check only one		Yes 2 No	
>	Physician: this certificantal director,	o Be	examiner?	ospital:	2 ER/Outpatier	nt 3 DOA	Othor		5 🗆 Residen		or (Specify)	
of	ding Phy h. After thi funeral	ı.	27. Manner of Death	28a. Date of Injury (Month, Day Yea			Injury at Work?		l. Describe how			
io	tending Factors tor: After the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(World, Buy 7 ou	ary mijary		1 ☐ Yes 2 ☐ I	No				
Division	r Atte er de recto by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	reet, factory, of	ffice	28f.	Location (Stre		er or Rural Route Num	nber,
	ital or rs aft all or all or all or all or all or all or all all or all all all all all all all all all al											
	Hospi 4 hou Funei ely fil	cal	(Check only 2 Medical Examin	ician: To the best of my er: On the basis of exar	knowledge, deat mination and/or in	h occurred at ti	he time, date an my opinion, deat	id place, and th occurred a	due to the cau at the time, dat	use(s) and mar te and place, a	nner as stated. nd due to the cause(s	s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Apmpletely filled in by the funer	Medical	29b. Signature and title of certifier	and manner stated.			icense number				(Month, Day, Year)	
<b>)</b>	L M C O	-	255. Signature drivers of certifier	rhin.	λ	1		28//			2	0
,	>		20 November 1	molated series of door	(Itam 22a) (Time	Print'	002	-011			2 15, Zer	, 7
			30. Name and address of person who con	YASH H		J"/ M	cons	RID	L	DSP!	7 11, 200 17 PICC 31318	Re
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature /	1	1.	4	. 07-70	, , ,	31218	
	Regist		IAM 2.2 200	A Dener	w D	span	KS				_	

\*

			For		State	of Maryla						lental Hy	giene	2001	0.07	· 1 - 9
	-		1 - State Registrar				Ce	rtificat	e of L	Death			Reg. No.	2004	l Uji	141
d	Physici	an	1. Decedent's Name (F	īrst, Middle, L M •	<sub>ast)</sub> Holte	n						2. Date of De Month January	Day	2004	3. Time of 5:35	Death PM
	/Medic Examin		Regina 4a. Facility Name (If no					4b. City,	Town, or	Location of	of Death	Sandary		County of De		1
	Examin.	E	Shady Gro	ve Adv	entist	Hospita	a1	Rock	vill	e			M	ontgon	ery	
	Funeral		5. Social Security Numb	oer 6.	Sex 1 □ M 2 🔏 F	7. Age (In yr	s. last birthday,	If Under Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da	th y, Year)	g. Bi	rthplace (State o	or Foreign
	Director		483-32-602 Usuat Residence of De		10.141 2051	69	Yrs.					Apr. 1,	193	4 Ic	wa	_
	yland now			b. County		10c. (	City, Town or L	ocation							10d. Inside C	
	e Mar	ctor	Maryland M	lontgom	ery	Re	ockvi11	е							1 □ Yes	2 🔼 No
	with th	Director	10e. Street and Numbe		D				Code 20853	•			•	en of What C	•	
	eath v	eral	14202 Cas	taway .		cedent Ever in	U.S. 13.				igin? (Sp	ecify Yes or No			enican Indian,	
9	or item	Fun	1 Never Married	2 Married	Armed F	orces? 2 ⊠ No	1	If Yes, spe				ecify Yes or No Rican, etc.)	į	Black, Wh		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show Tra Medical Exertiner; and the indiffical at	Completed by Funeral	3 Widowed 4		If Yes, G Year or	Dates:				Specify:					hite	
15-	n 72 h "natu edica	lete	(Specify o		Education rade completed	)	16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa ork done d ise retired	ation <i>Juring mo</i> s	t of work	ing	16b. Kir	d of Busines	s/industry	
712	l withi	omp	Elementary/Seconda	ry (0-12)	College 4	(1-4or 5+)	Teac			,			Ed	ucatio	n	
ğ	e filec al Hyg I othe vent,	BeC	17. Father's Name (Firs	st, Middle, Las	it)							e (First, Middle,		Sumame)		
Maryland	ould b Ments arked	P	Edward Ma									Connor				
Mar	d 2 sh th and 7 is rr traum		John W. H			ınd		ng Address 2 Cas				Rockwi 1			<i>Zip Code)</i> .nd 2085	3
ف	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examinet and be notified at once.		20a. Method of Disposit	tion		20b	Place of Dispo				[	Date			r Town, State	
Baltimore,	Page Mr. Fr		1 X Burial 2 □ C 14 □ Donation 5 □			State	ite of I			١,	Jan. 2004	,	Silv	er Spr	ing, MD	
alti	spartm sports sports iy inju	. 8	21. Signature of Funera	al Service Lie	ensee		2	2. Name ar	nd Addres		-	Vol Fun				
	20 E 2 9	X 10	1/	W C	, Wu			) E. 1						ırg, M		
Б			23a. Part1. Enjer the d shock, or heart fa Immediate Cause (Fina						ie ot dylne	g, such as	cardiac	or respiratory ai	rest,		Approximat Interval Bet Onset and	e ween Death
	Pnysician /Medical		disease or condition resulting in death)		a	teral P	neumon:	ia	_		_	-			11 Days	5
	Examiner		Conversion to the second		b	(-, ,										
	p ii	Iner	Sequentially list conditi if any, leading to imme cause. Enter Underlyin	diate	* Due to	(or as a cons	equence of):									
_	and and II-tran	Examiner	that initiated events resulting in death) Last		c. Due to	o (or as a cons	equence of);	_								
760,	ate be executed hysician and the burial-transit	calE		Į	<b>.</b> d											
89	tificating phy as the		15.55111.5			100.0	2.5									
Вох	ath cei ttendir or use	Physician/Med	23b. Was decedent pre in the past 12 mo		1 ☐ Live	utcome of preg birth 2 - Fe	etal death 3	⊒Ectopic p					2	3d. Date of de	-	Year
0	he de	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown		4∐Preg 9□ Unk	nant at time of nown	fdeath 5[	Other (sp	oecify)						,	
۵.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It	by Ph	Part II. Other significat	nt conditions	contributing to	death but not r	esulting in the u	inderlying o	ause give	n in Part I		23e. Did to	obacco us	e contribute	o the cause of	leath?
rds	w requires been sign should be											1 🗆 1	/es 2[	]No 3∏F	robably 4 🕅	Jnknown
Records,	e law requ has been je 2 shouli	Completed										24a. Was	SV	24b. Were a	utopsy findings completion of c	available ause of
		Con										perfo	rmed? 2∭ No	death? 1 ☐ Ye	s 2□No	
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☒ No	to medical	Hospital: 🔻	Ilanoticat 2			Othe	\r.		(Check only o		CO** (0		
of	<u>a</u> = <u>a</u>	H- 1	27. Manner of Death		28a. Date		28b. Time o		28c. Injury Work	at		me 5 🗌 Resid 28d. Describe h			эсіту)	
ior	Attanding r death. sctor: After by the fune	atlo	2 Accident	Pending investigati	on	nui, Day Tour,	Injury	М		res 2 🗆	No					
Division	i i i e	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not determine	d 286. Plac	e of Injury - At ding, etc. (Spe	home, farm, st cify)	reet, factor	y, office			28f. Location (5 City or Tow		Number or F	lural Route Num	ber,
ш	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1	Certifying F	hysician: To th	e best of my k	nowledge, deal	h occurred	at the tim	ie. date an	d place.	and due to the	cause(s)	and manner a	s stated.	
	n 24 h	edical	(Check only 2 one)	Medical Ex	aminer: On the	basis of exami nner stated.	nation and/or in	vestigation	ı, in my op	oinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(s	:)
	To the To the Comp	Ž	29b. Signature and title	certifier			Α.4.		c. License				29d. Date	signed (Mon	th, Day, Year)	
•	*		MA	WY.				10	D58	3681			Janu	ary 18	, 2004	
	1		30. Name and address		nder, M				ente	r Dr.	Ro	ckville	, Ma	ry1and	20850	
	Sta	ite	31. Date filed (Month, L	Day, Year)	32.	Registrar's Sig	nature /						-			
	Regist	ar	.IAI	N 2 0 2	2004	Genera		Jap.	als							

			For State Registrar	State of Marylar			of Healt of Dea	th	R	eg. No.	04	0 0 0 1 0
54	Dhyciai	an a	1. Decedent's Name (First, Middle, La	ast)				:	<ol><li>Date of Deal Month</li></ol>		Year	3. Time of Death
	Physici /Medic	_	Antonio	Casado	Не	rnan			Jan.2	1,200		4:14p M
	Examin		4a. Fecility Name (If not institution, gir	ve street and number)			fown, or Locati			4c. Count		
14			Casey House			1	ckvill				tgom	
	Funeral Director		580-14-0803	Sex 7. Age (In yrs 1	. last birthday) Yrs.	If Under Months	Days Hou	irs Min.	8. Date of Birth (Month, Day) Tuly 1	, 1943	9. Birthp Coun Spai	lece (State or Foreign htry) . n
	Maryland f show	or	Usual Residence of Decedent           10a. State         10b. County           MD         Montgo		ity, Town or Lo		ng				1	0d. tnside City Limits 1 ☐ Yes 2 ☑ No
	sa or 28a-	Funeral Director	10e. Street and Number 1808 Sanford R	oad		10f. Zip	Code 902		1	0g. Citizen of USA	What Cour	ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantral must be a willied at	þ	11. Maritat Status  1 □ Never Mamed 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates:				origin? (Spec cican, Puerto R city: Spai	city Yes or No- lican, etc.)		ce - Americ ck, White, fy: Wh	
Maryland 21215-0036	within 72 ho ene. than "neture he Medical I	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education ade completed) College (1-4or 5+)	16a. Decer (Give life. But	kind of wor DO NOT us	Occupation k done during i e retired)	most of working		16b. Kind of E		dustry f Spain
land 2	uld be filed fental Hygierked other fic event, the	To Be Co	17. Father's Name (First, Middle, Las Manuel Casado	•					(First, Middle, i			dez
Mary	1 and 2 shoul Health and Mi Iem 27 is mari		19a. Informant's Name/Relationship Maria Del Pila	<sup>(Type, Print)</sup> r Casado/Wii	19b. Mailir E	ng Address 08 Sa	(Street and Nu	mber or Rural Road	Route Number Silve	r City or Town	, State, Zip ing , l	Code) Md 20902
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	Place of Dispo cemetery, crei Chesap	matory or ot	her place)	1/24/		20c. Location Belts	-	
Balti	permit. Departm Departm Imports any inju		21. Signature of Funeral Service Like		P 19	Name and HILI 241 (	Address of Fi P D.RI Columb	NALDI	FUNER	AL SE	RVIC	E,P.A. g,Md20910
use.	Physician		23a. Pert1. Enter the disease, or cor shock, or heint failure. List only tmmediate Cause (Final disease or condition	nplications that caused the dea y one cause on each line.	ath. Do not ent	er the mode	of dying, such	n as cardiac or				Approximate Interval Between Onset and Death
,092	/Medical Examiner  hysician and lihe burial-transit	lical Examiner	Sequentially list conditions. If any, loading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consect of the c	quenca of):							
.O. Box 68	death certific e attending p od for use as 1	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊒Ectopic pre ☑ Other ( <i>spe</i>		===			ate of delive	ory Day Year
۵.	ures that signed by	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	inderlying ca	use given in P	'art I.				ne cause of death?
Vital Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed					·		24a. Was a autops perform		prior to cor death?	psy findings available mpletion of cause of
VIII:	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitat:	7				(Check only or			hognico
of	ding After fune	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigeti	28a. Date of Injury (Month, Day Year)	28b. Time o tnjury		A 4 4 Bc. Injury at Work? 1 ☐ Yes 2	21	te 5 ☐ Reside 8d. Describe he			hospice
Division	or Attendent fler deat prector: in by the	Certification:	2 Accident Investigeti 3 Suicide 6 Could not 4 Homicide determine	be one Blace of taking At	home, larm, str cify)			-	8f. Location (Si City or Town		ber or Rura	I Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Cartifying F 2 Madical Example	Physician: To the best of my kr minar: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred a vestigation,	at the time, date in my opinion,	e and place, at death occurre	nd due to the c d at the time, d	ause(s) and m ate and place,	anner as st and due to	tated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier	inford-		29c	D424		2	9d. Date signe 1 / 21		
	arphi		30. Name and address of person who Chitra Rajago	V			Philli	p Dr.	Olney	. ма .	20825	
	Sta Regist		31. Date liled (Month, Day, Year)  JAN 23	32. Registrar's Sign	nature	Sp	als		7	,	- • • • •	

Antonio Casado

State of Maryland / Department of Health and Mental Hygiene 03849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 08 **Physician**  $\mathbf{J}\mathbf{A}\mathbf{N}$ GEORGE HEILBORN 2004 7:45 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1X M 2□ F Yrs. Director 01/31/1925 GERMANY 102-20-3960 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location or 28a-f show Examiner most be notified at 1 ☐ Yes 2 No Directo VIENNA VIRGINIA FAIRFAX 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a 22182 8722 OLD COURTHOUSE RD. U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel important: If item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1949-85 1 ☐ Yes 2X No Specify: Specify:WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GEOLOGIST FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ HERMAN HEILBORN JULIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN HEILBORN/WIFE 8722 OLD COURTHOUSE RD., VIENNA, VIRGINIA 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2/□ Cremation 3 □ Removal from State QUANTICO NAT'L CEM. 01/16/2004 QUANTICO. VIRGINIA 4 □Donation / 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 tukey n. 1226 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician LUNG CANCER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy ŏ Day Year 5 Other (specify) P.O. ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: X Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pendina To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 01055104A Jon, 09, 2004 (IN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MICHAEL R. BAYDARIAN LT MC BETHESDA MD 20889-5600 **HSNR** 31. Date filed (Month, Day, Year)

JAN 2 0 2004 32. Pegistrar's Signature State ookst Registrar

		1 - For State Registrer	State of Marylan		rtment of H		nd Mental Hy	giene Reg. No.	20.04	03850
		1. Decedent's Name (First, Middle, Last)					2. Date of De		Yeer	3. Time of Death
Physi /Med	ician dical	Kathleen Goldie B	rown Hardman				Januar		2004	2:11 A M
Exam		4a. Fecility Name (If not institution, give st			4b. City, Town, or	Location of	Death		unty of Deeth	
		Montgomery General		la an triadh da . N	Olney If Under 1 Year	If Under 2	4 Hrs   a Date of Bi		tgomer	-
Funera Directo		5. Social Security Number 6. Sex 1	7. Age (In yrs. 88		Months Days	Hours	Min. June	7 Year) 19	15 New	plece (State or Foreign ntry) ark, NJ
	"	Usuel Residence of Decedent								
nylan how		10a. State 10b. County		y, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
e Ma	cto	Maryland	San	dy Spr						
vith th	Directo	10e. Street and Number	0.10		10f. Zip Code				of What Cou	
s 23e	6	17310 Quaker Lane	C IU  2. Was Decedent Ever in U.	S 13 V	20860	ispanic Origi	n? (Specify Yes or N	1	ed Stai	
ter de	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🎇 No		f Yes, specify Cuba	in, Mexican,	Puerto Rican, etc.)		Bleck, White,	
urs al	Ş	3 ☐ Widowed 4 ▓ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Sp A	ecity: frican	American
If Z 12.1 5-0050 filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23e or 28e-f ehow ont, the Medical Erans or must be notified.	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	tent's Usual Occup	durina most o	of working	1	of Business/Ir	
Aithin Mithin	Jan	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	•		M- 44	1	
lied w dygien ther ti	S		5+	Keg	istered l		s Name (First, Middle	Medio		
d be findal head of	Be	- T					leen Goldi			
partitioner, interpretation 2.12.13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or gither traumatic event, the Modical Exams as mouth be notified.	J.	19a. Informant's Name/Relationship (Typ	<i>e. P&amp;</i> ttendaughte	r19b. Mailir	ng Address (Street					p Code)
and 2 sealth ar n 27 le	1	Youtha C. Hardman-					Washingto			009-4434
S Lag		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date	_	ion - City or T	own, State
Pages nent of nnt: If it	P	1 ☐ Burial 2 ☐ Cremation 3 🖾 Re  1 ☐ Donation 5 ☐ Other (Specify)	moval from State  _		Cemeter		1/26/04	Hills	side, 1	New Jersey
Dallillor permit. Pages Department of important: if it	ġ	21. Signature of Funeral Service License	200				McGuire Fu			ce
0 8855	a	Thomas D.C	Lynn	7	400 Georg	gia Av	e. N.W., V	lash. I	).C. 2	20012
	*	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat e cause on each line.	h. Do not ent	er the mode of dyin	ng, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition	Myocarnia	u Di	FARCT O	2				12days
/Medica		resulting in death)	Due to (or as a conseq							3
LAGIIII		Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq		TREMITY	TSC	elenia.			
ted	n lu	cause. Enter Underlying Cause (Disease or injury	2,00	71.51	م حد					
ou, be executed ician and burial-transit	Fxaminer	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):	410)			-		
veguires that the death certificate be executed veguires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	leal 1	<b>€</b> d.								
certificat certificat nding phy use as th	100									
ath cer attendir for use	hvelclan/Med	IF FEMALE: 23b. Was decedent pregnant 23	lc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	incy Ideath 3□	Ectopic pregnancy	,		23d	I. Date of deliv	rery Day Year
e dea he att	2	in the past 12 months?  1 Yes 2 No	4 Pregnant at time of d 9 Unknown	eath 5	Other (specify)				MOILI	Day Toal
ecords, F.O. BG law requires that the death as been signed by the atter 2 should be detached for u	Phy	9 ☐ Unknown Part II, Other significant conditions con	tributing to dooth but not rec	ulting in the u	adorhina cauca au	on in Part I	23a Did	tobacco use	contribute to	the cause of death?
res the signe	2		inbuting to death but not res	untang an tine u	ildanying cadsa giv	on in raiti.		Yes 2 🗹	,	bably 4 Unknown
law requires las been signed 2 should be	omnleted									anny findings sysulable
has law	2							psy ormed?_	prior to co death?	opsy findings available ompletion of cause of
VITAI MEC sician: The law s certificate has b lirector, page 2 s	2					00 81	1 Yes		1 🗆 Yes	2 □ No
Of Vital Physician: rthis certific ral director,	a	examiner?	ospital:	ER/Outpatier	nt 3 DOA Oth	00	of Death (Check only sing Home 5 Res		Other (Speci	fv)
P P S S S S S S S S S S S S S S S S S S	.   H		28a. Date of Injury (Month, Day Yeer)	28b. Time o			28d. Describe			-97
nding ath. r: Aft	1	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monus, Day 1991)	Injury		Yes 2 □ N	0			
UNISION  or Attending after death. Director: After	Cartification.	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office	00		(Street and Nown, State)	umber or Rur	al Route Number,
ital or rate of in led in led in	20		1							
DIVISION  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	2	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	Icien: To the best of my known of the basis of examination							
the the the mplet	Madical	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d Date s	igned (Month,	Day Year)
2369			444445			060	964	01/18		
7		30. Name and address of person who con	moleted cause of death (Item	n 23a) (Tuna			- 1	01/18	-	
		BRUNO SCHREMME		1 AOSE		E B	ETHERDA. 1	10 20	814	
10 3	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa		Sporks			- 10		
Regi			4 for application	fred	the course					

			1 - For State Registrer	State of Ma	ryland	/ Depa	rtmen tificate	t of H	ealth a D <i>eath</i>	and Mer		ene { g. No.	2001	03851
П	Physici	an	1. Decedent's Name (First, Middle, Last)	,							Date of Death Month	Day	Year	3. Time of Death
4	/Medi			HAIM							NUARY	10,	2004	4:35 P M
	Examir	ner	4a. Facility Name (If not institution, give s	,					Location of				ounty of Dea	
			HOLY CROSS HOSPITAL  5. Social Security Number 6. Sex		(In yrs. las	t hirthday)	SILV:		PRING If Under 2		Data of Risth	MO	NTGOME	
п	Funeral Director			M 2□F / 799	73	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, /30/19		C	thplace (State or Foreign ountry)
			Usual Residence of Decedent		/						/ 30/ 19	30	INEW	YORK
	show		10a. State 10b. County		10c. City, T	own or Lo	cation					_		10d. Inside City Limits
	Ba-f s	cto	MARYLAND MONTGOMERY		SILVE	R SPI	RING							1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number				10f. Zip	Code			10		on of What Co	ountry?
	s 23a		104 ELDRID DRIVE			1	<del></del>	904				U.S		
	ltam Iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 ∑Yes 2 ☐ N</li> </ol>		13. V	Vas Deced Yes, spec	ify Cubar	spanic Orig n, Mexican,	in? (Specify , Puerto Rica	Yes or No- in, etc.)	14	Race - Ame Black, Whit	
39	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Q 1	☐ Yes 2	2⊠ No	Specify:			S	pecify: W	HITE
Š	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show fe Madical Examirer must be notified at	ted	15. Decedent's Educ	ation		6a. Deced	ent's Usua	I Occupa	tion		1	6b. Kind	of Business	<del></del>
215	within 7 ane. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. [	OO NOT us	k done di e retired)	uring most	of working				
7	filed within Hygiene. other than ant, Ine M	Cou		5+		BGYN					N	EDI	CAL	
p	d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (Fil	rst, Middle, M	aiden Su	umame)	
Ž	ould Men varke	ျှ	IRVING	HAIM					MILDR				SANGE	
Maryland 21215-0036	12 sh h and 7 Is m		19a. Informant's Name/Relationship (Typ	e, Print)							oute Number,		Town, State, 2	Zip Code)
	es 1 and 2 should be filed of Health and Mental Hygis If item 27 is marked other ir other traumatic evant, II.		GEOFFREY HAIM/SON  20a. Method of Disposition			e of Dispos			., IK	MO, SC Date	29063		ition - City or	Tourn State
Baltimore,	permit. Pages Department of I Important: If its any injury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	cem	etery, crem	atory or of	ther place						
를	and and and and and and and and and and		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Lieense</li> </ul>	. ^	NATIO				of Facility		2004 FA	LLS	CHURC	H, VIRGINIA
Ba	permit. Depart Import any in		Manual C.	Ston	Zem						R <del>JREGTI</del>	ρŊ,	INC MD 20	0.50
			23a. Part1. Enter the disease, or complic	ations that caused	the death. I								FID 20	Approximate
	Physician	ē	snock, or near failure. List only one	e cause on each lin	е.									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	CORONARY Due to (or as a			DEASE						-	YEARS
н	Examiner		Communication first annualisation in the											
	D =	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce of):								
	ecute and trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last											
00	oe execian a		resulting in death) Last	Due to (or as a	consequen	ce of):								
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical	d.											
9 X	leath certific attending p	Physician/Me	IF FEMALE:	c. If yes, outcome of	of pregnancy	,								
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal de	ath 3□	Ectopic pre					230	<li>d. Date of del Month</li>	ivery Day Year
o.	the y th iche	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	0. 0000		Ottion (spe							
Δ.	requires that een signed b hould be deta	by Pt	Part II. Other significant conditions conf	ributing to death bu	t not resultin	g in the un	derlying ca	use give	n in Part I.		23e. Did toba	cco use	contribute to	the cause of death?
rds	n sign	d b	CHRONIC OBSTRUCTIVE	PULMONA	RY DIS	EASE					1 🗓 Yes	2 🗆 1	No 3□Pr	obably 4 Unknown
00	~ Q 75	Completed	ACUTE BRONCHITIS								24a. Was an	2	24b. Were au	topsy findings available completion of cause of
æ	o	E O								_	autopsy perform 1 ☐ Yes 2	ed?	death?	completion of cause of
of Vital Records,	ician: Th certificate rector, pag	0	DIABETES MELLITUS 25. Was case referred to medical		-				26. Place o		eck only one		1 1 105	2   NO
<b>&gt;</b>	8 s = 5	ToB	examiner? 1 ☐ Yes 2 🔯 No	ospital: 1 🕅 Inpatier	t 2 ER	Outpatient/	3 DO	A Other	. 4 🗆 Nurs	sing Home	5 Residen	ce 6 [	Other (Spec	cify)
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury	28	Bc. Injury Work	at ?	28d.	Describe how	injury o	occurred	
Sio	Attanding ir death. ector: After by the fune	catio	2 Accident investigation				М	1 🗆 Y	es 2 □N	lo				
Division	after death after death Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home . <i>(Specify)</i>	, farm, stre	et, factory,	office		28f. l	Location (Stre City or Town,	et and N State)	Vumber or Ru	ral Route Number,
	Hospital (		20a Cartifier 4M cantainer	elen Trata	( mu ) = (	den de de								
	To tha Hospital or At within 24 hours after o To tha Funaral Directompletely filled in by	edical	29a. Certifier 1 ☐ Certifying Physi (Check only one) 2 ☐ Medical Examin	er: On the basis of and manner stat	examination	and/or inv	occurred a estigation,	in my opi	e, date and nion, death	place, and on noccurred at	the time, dat	se(s) an e and pla	id manner as ace, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Med	29b. Signature and title of certifier				29c.	License	number		296	d. Date s	signed (Month	n, Day, Year)
	- SHO		banks /2)	1 second	- , <i>y</i>	UD	DO	0250	80					
	20		30. Name and address of person who con	npleted cause of de				0.4300	50		1 J E	INUA!	RY 10,	~UU4
			FRANK GRAVINO, M.D.					STL	VER S	PRING	MARYI	AND.	20902	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		1	34 -		TITING	THILL	LAMP	~0302	
	Registr	ar	JAN 2 0 2004	1 Dene	مصو	D	200	uls						

			For State Registrar		Sta	ate of	Marylar	nd / Depa <i>Ce</i>		nt of H te of L			ental Hy	gien Reg. No	- 21101.	03852
			1. Decedent's Name	(First, Middle,	Last)								2. Date of De		Vans	3. Time of Death
	Physici		C	ertrude	Un f 1	f o b								Da v 16	y Yeer • 2004	6:54P M
3	/Medio		4a. Facility Name (If				per)		4b. Cit	, Town, or	Location o		Julius I		. County of Death	
	LAGITIII	CI	Montgomer	cw Cana	rol H	nenit	· a 1		011	AV					Montgome	rv
	Funeral		5. Social Security Nu	umber	6. Sex	7	Age (In yrs.	last birthday)	If Und	r 1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D			nplace (State or Foreign untry)
	Director		024-05-6	5462	1□ M 2	K⊡F	85	Yrs.	Months	Days	Hours	Min.	Novembe	er29	.1918 Ma	ssachusetts
	ס		Usual Residence of						1							
	how		10a. State	10b. County			10c. Ci	ty, Town or L	ocation							10d. Inside City Limits
	Ma-f	흥	Maryland	Montg	omery		Si	lver S	pring	5						1 ☐ Yes 2 💢 No
	는 62 명 문 28	Director	10e. Street and Nurr	nber					10f. Z	ip Code				10 <b>g</b> . C	itizen of What Cou	untry?
	be filed within 72 hours after death with the Maryland nat Hygiene. Ad other than "natural", or items 23e or 28e-f ehow event, the Medical Exam are must be notified at	20	3310 Nort	h Leis	ure We	or1d	Blvd.			20906					.S.A.	
	ens ens	Funeral	11. Marital Status		12. W	as Deced med Forc	ent Ever in U	J.S. 13.	Was Dec If Yes, sp	edent of Hi ecry Cuba	spanic Ori n, Mexican	gin? (Spe 1. Puerto F	city Yes or No Rican, etc.)	0-	14. Race - Amer Black, White	
9	or It	F	1 Never Marrie		lf '	☐Yes 2 Yes, Give			1 🗆 Yes	2 🕅 No	Specify:				Specify:	
21215-0036	ural',	Completed by	3 Widowed			ear or Dat	<b>9</b> 5:							1 400 1	Whi	
5	72 nation	ete	(Speci	15. Decedent' ify only highest				16a. Dece	kind of w	ual Occupa rork done d use retired,	ition <i>Juring m</i> osi	t of workin	ng	16b. F	(ind of Business/I	ndustry
12	han han	d E	Elementary/Secon	ndary (0-12)	Co	ollege (1-4	lor 5+)				,					_
	Hygie Hygie other I		17. Father's Name (	First Middle I	asti	,	-	Т В	ookke	eper	18. Mothe	er's Name	(First, Middle		ccountin n Sumame)	8
JUE	be for	Be			20.,	/							Skoln:			
Maryland	2 should be fited withir and Mental Hygiene. is marked other than aumatic event, Lie M.	ဥ	Louis E		in /Tuna P	rint)		10h Maili	na Addra	ss /Street s					or Town, State, Z	in Code)
Ma	12 s h an 7 is r traur					"""										,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	1 and 1 Health tem 27		Mark Ha		SOII		20b.	Place of Disor	osition /N	ame of	Į.		ille, N	1	ocation - City or 7	Town, State
ō	Pages nent of I int: If it		1 KBurial 2	Cremation		al from St	ate	cemetery, cre	matory or	other place		1 10	0.4			
tir	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke injury or other traumatic		* 4 Donation				T.eu	mple As				1-19			rett,Måss	5.
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Fur	neral Service L	Censee								s-Rina			
	402 6 G		23a, Part I. Enter th	_ ( . /	jun		seed the dee								ver Spri	ng, MD 20904
E			shock, or hear	rt failure. List o	only one cau	is that cat	ch line.	in. Do noi en	ter the m	oue or dyling	y, such as	cardiac of	r respiratory a	111051,		Interval Between Onset and Death
	Physician		Immediate Cause (	Final n	_ a	Hea		Forla	12							
	/Medical Examiner		resulting in death)			Due to (o	r as a conse	quence of):								
	LXammer		Sequentially list con	nditions,	b		r as a conse									
	sit ad	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	mediate rlying		Due to (o	rasa consex	quence or):								
	ecute and -tran	cam	that initiated events resulting in death) L		c	Due to (o	r as a conse	allence of).								
8760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	E	,			D40 10 (0	43 4 00/130	4001100 01).								
87	ohysin the t	dlcal			d											
9	death certific attending p	Me	IF FEMALE:		220 16	voc outo	ome of pregn	2001								
Вох	ath c	lan	23b. Was decedent in the past 12.		11	Live bin	th 2 ☐ Fet	al death 3		pregnancy					23d. Date of deli- Month	very Day Year
	e de the a	Physiclan/Me	in the past 12, 1 ☐ Yes 2 Ø 9 ☐ Unknown	No No		∐Pregna □Unknov	nt at time of one	death 5	Other (	specify)						
P.O.	that the de ned by the a		Part II. Other signifi	icant conditio	ne contribut	ing to dea	oth but not re	sulting in the I	ınderivino	Callea Cive	n in Part I		23e. Did	tobacco	use contribute to	the cause of death?
S,	signed d be det	by	Fait II. Othor signif	icani conditio	CONTINUE	ing to dec	itii bat not ro	saiding in the t	angonying	oddad girl	J	•		Yes 2		bably 4 Unknown
oro	v require been si should I	ted							·							
Records,	> 110	Completed											24a. Was	POSV	prior to c	topsy findings available ompletion of cause of
<b>E</b>	The ate h	Son											1 ☐ Yes	ormed? 2∏ N	death? 1 ☐ Yes	2 □ No
ita/	sian: artific ctor,	Be	25. Was case referr	red to medical								of Death	(Check only	one)		
- J	hysic his o	2	1 □ Yes 2X		Hospit	12A In		ER/Outpatie			4 🔲 NU			·	6 ☐Other (Spec	ify)
n c	ng P	ü	27. Manner of Death  1 X Natural	h 5 ☐ Pending	28	a. Date of (Month	Injury , <i>Day</i> Year)	28b. Time of Injury		28c. Injury Work			28d. Describe	how inju	iry occurred	
Si O	Attending or death.  ector: After by the funer	catl	2 Accident	investig 6 ☐ Could n	ation				М		Yes 2 🗌					
Division of Vital	irect irect	Certification:	3 🗍 Suicide 4 🔲 Homicide	determi	ned 28	e. Place o building	of Injury - At h g, etc. <i>(Spec</i> .	nome, farm, st ify)	reet, facto	ory, office		2	28f. Location City or To			ral Route Number,
	ital c			77								- 1				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only		Examiner: (	on the bas	sis of examin								s) and manner as id place, and due	
	the hin 2 the the h	Med	one)	<b>a</b>		ind manne	er stated.			On Linnar	aumhar			20d D	ata singed /Month	Day Yarr
		-	29b. Signature and	utte of certifier	1				2	9c. License	number			290. Da	ate signed (Month	, Dey, redr)
	10		10	110)	~					F375	535			1/	17/2004	
			30. Name and addr									0000	20			
			DR. Den:		ien	7		ndwood		,		2083	32			
	St Regist	ate rar	31. Date filed (Mon.	AN 22	2004	32. He	gistrar's Sign	S S	Si	ants	1					
	riegist	TEIL T	1 01	FEE IN IN	LUUT	10			//							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend# 5.Per Fam.PGC 1-28-04 cr Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 18, 2004 Margaret Wheeler Harrod 5:30AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Cheverly Prince George Prince Georges Hospital If Under 1 Year If Under 24 Hrs. 5 Social Security Number 123-46-0512 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖸 F Months Hours 49 Yrs. June 10, 1954 Director Wash, D.C. Usual Residence of Decedent be filed within 72 hours after death with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 12⊠ Yes 2 □ No Directo Riverdale or 28a-f Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 United States items 23a 6708 Auburn Avenue Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married ò B1ack Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Management Analyst permit. Pages 1 and 2 should be fit.
Department of Haelth and Mantal Hy
Important: If Item 27 is merked other
any injury or other traumers. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Green Margaret Robert Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6708 Auburn Avenue, Riverdale, MD. Roy Harrod/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State 01/23/2004 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, MD. Funeral Homes Marlboro Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20747 Forestville, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) a ANTENIOSCIENOTIC CANDIDIVAGUAJAN Divente yeery Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and Division of Vital Records, P.O. Box 68760. by Physiclan/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Diabetes Wellitus 1 YUS BEING 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred after death. 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funeral L 29a. Certifier 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medicai within 24 ho To the Fune completaly f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

CR (10)
State

Denald George, MiD, 31. Date filed (Month, Day, Year) 32. Registrar's Sig JAN 2 I 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

7305 A

DO182

- Hanover Pkwy Greenbelt, MD20770

				Sta	ite of M	laryland	•		of Health of Death		nental Hy	/giene Reg. No.2	04	03854
,	Physici	an	1. Decedent's Name (First, Mic								2. Date of D		Year	3. Time of Death
	Physici /Medio		_	a Mae How							Januar	y 10, 2004	+	3:29 AM
)	Examin	er	4a Facility Name (If not institu							_	ocation of Dea		y of Death	_
	Funeral		Prince George's 5. Social Security Number	Hospital 6. Sex			st birthday)	If Under 1 Y	ear If Under	Chever or 24 Hrs.	8. Date of Bi	Prince	9. Birtho	2 <sup>1</sup> S
	Director		578-86-8991	1□ M 2			32 Yrs.	Months D	ays Hours	Min.		ay, Year) ⊇r 12, 192		lace (State or Foreign try) th Carolina
	pur *		Usual Residence of Decedent 10a. State 10b. Cour			100 City	Town or Loc	action			-chcain	-12-12		
	Maryla -faho	ţ		ce George	's	Too. Oily,	TOWN OF LOC		ple Hills	s			'	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th the or 28s	irec	10e. Street and Number					10f. Zip Co				10g. Citizen of		try?
	ath wi	ral	4012 28th Ave	nue Apt. #	#202				20748			U.S.	Α.	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 ☒ Widowed 4 □ Divorc	arried 1 [	s Decedent ned Forces? Yes 2 X es, Give ar or Dates:	,		Vas Decedent Yes, specify □ ☐ Yes 2【X	of Hispanic Or Cuban, Mexica No Specify		ecify Yes or N Rican, etc.)	0- 14. Ra Bla Specii	ce - Americ ck, White, fy: Bla	etc.
15-(	"natu	letec	15. Deced (Specify only high	ent's Education he <i>st grad</i> e co <i>mp</i>	leted)		16a. Decede (Give k	ent's Usual Oci and of work de	ccupation one during mos stired)	st of work	ing	16b. Kind of B	Business/Inc	lustry
212	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, ms Ms	Completed by	Elementary/Secondary (0-12 10th grade	) Col	lege (1-4or	5+)		empl <i>oy</i> e					N/A	
pu	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle	e, <i>Last)</i> y Peoples					18. Moth			, Maiden Surnai	me)	
Maryland	should ind Men i marke umatic	၉	19a. Informant's Name/Relatio	•	nt)		19h Mailing	Address (St	reet and Numb		e Ellen V	er, City or Town	Stato Zin	Code
	1 and 2 s Health ar em 27 ls		Emestine H. Low				4012 2	28th Ave	nue Apt.	#202	Temple I	Hills, Mar	yland	20748
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1  ↑  Burial 2 □ Crematio	n 3 □Remova	I from State	cer	netery, crem	ition (Name o atory or other	place)		Date	20c. Location	•	
Ħ	permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other	(Specify)		Hann		orial P			L/17/04	Landover		
Ba	pemit. Departn Importa any Injt		21. Signature of Funeral Service	Licensee	nole	und			dress of Facili PL. N.E.	7		UNERAL HO D.C. 200		J.
a deline	Physician /Medical Examiner	Je.	23a. Pan. Enter the disease, spoot, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	st only one caus	hy	28	Aconseque	Smi	_	_		rsaly	dos	Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the bunal-transit	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	Las	pr	as a consequence as a consequence	onto	Eul	luc	)			
	death e atter	icia	Part II. Other significent condi	tions contribution	n to death h	ut not result	ing in the unc	derlying cause	given in Part I	1	23h Did	tohacco use co	ntribute to	the cause of death?
, P.O	res that the designed by the ail	Phy			g 10 ddui 7 D	at Hot Foodit	ang an old dile	soriying oddoo		1.	_	Yes 2√ No		ably 4 □ Unknown
Records,	e law requires has been sigr ge 2 should be	Completed by									24a. Was perfo	an autopsy ormed?	ava	re autopsy findings ilable prior to spletion of cause eath?
alF											10	Yes 2 XIII	10	Yes 2™No
Vital	rect est	o Be	25. Was case referred to medic examiner?	al Hospital:			210	V	Othor:		(Check only o			
of	ling Phys n. After this funeral di		1 ☐ Yes 2 ☑ No  27. Manner of Death  Natural 5 ☐ Pend	ling 28a.	1 ☐ Inpatie Date of Injui (Month, Day	ry 2	R/Outpatient  8b. Time of Injury	28c. [	njury at Work?	2		dence 6 □Oth how injury occur		
Division	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edical Certification:	3 ☐ Suicide 6 ☐ Coul	mined 286.	Place of Injubuilding, etc		e, farm, stree	et, factory, offi	I □ Yes 2 □		28f. Location (. City or To	Street and Numb wn, State)	er or Rural	Route Number,
_	Hospital 24 hours e Funeral I	Salca	(Check only 2 Medica	ing Physician: 1	the basis of	examination	adge, daath a	course at the	etime, date an ny opinion, dea	id place, a ith occurre	and due to the	cause(s) and ma date and place,	inner as eta and due to	ted. the cause(s)
	To the vithin 2		one) 29b. Signature and title of certif	and	manner sta	iled.		1	ense number			29d. Date signe		
			Mando	1/6	4			D	31528			1/12	101	L
/	(2)		30. Name and address of person	n who completed , M.D. 612	cause of de 28 Land	eath (1 m 2 over Ro	3a) (Type, Pr	erlv. M	arvlam	20785		1	1	
	Stat Registra	- I	JAN 2 1 2	r)	32 Registre	ar's Signatur			- J	20,00				

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

00	459			Please	Type or Prir					=		egible.	
			For State Registrar			aryland /		artment of F	lealth and N Death	F	Reg. No.	2004	03856
	Physicia	an l		e (First, Middle, Las	st)					2. Date of Dea		<b>,</b> 2004	3. Time of Death
	/Medic		Kennet			Henson				Udildal	-		0/40 F.W
1	Examin	er			e street and number)			4b. City, Town, o	r Location of Death			ounty of Death	
_			5. Social Security N		ntist Hosp	OLTAL e (In yrs. last bi	irthday)	Tak If Under 1 Year	oma If Under 24 Hrs.	8. Date of Birth	h	ontgome: 9. Birthp	
	Funeral Director		578-90		M 2□F	43	Yrs.	Months Days	Hours Min.	(Month, Da) Dec. 11	v, Year)		ace (State or Foreign try) ash.,DC
			Usual Residence of							Decti	- /		
	nylan show		10a. State	10b. County		10c. City, Tov						11	0d. Inside City Limits 1X Yes 2 □ No
	Ba-f.	cto	Md.	Montgon	nery	Sil	Lve	r Spring	3		10 000		
	vith th	듬	10e. Street and Nu					10f. Zip Code 209	1.0			n of What Coun	•
	s 23e	Funeral Director		Modrad W	a y 12. Was Decedent	Ever in IIS	13 1			ecify Yes or No-		Race Americ	
_	ter de	'n.	11. Marital Status 1 □ Never Marr	ried 2 XMarried	Armed Forces? 1 ☐ Yes 2 🔀		1		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	į	Black, White,	
0000	filed within 72 hours after death with the Maryland Hygiene. Nther than "natural", or items 23e or 28e-f show ent, the Madical Examiner institut an initiad at	þ	3 🗌 Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2 <b>X</b> No	Specify:		S	pecify: B1	ack
ָ ר	72 ho	Completed	(Sner	15. Decedent's Ec	ducation	168	(Give	dent's Usual Occup	during most of work	ina	16b. Kind	of Business/Inc	lustry
7	ithin 19.	nple	Elementary/Seco		College (1-4or 5		life.	DO NOT use retired	d)				
7	led w lygier her th		12	(First, Middle, Last)	1	C	ust	omer Se	rvice R			Ikea	
	ould be fi Mental H arked ot atic ever	Be	Cornel		nson				Lorrai		chie	arriarrio,	
	should and Men marke umatic	၉		lame/Relationship (		19	b. Mailir	na Address (Street	and Number or Ru			Town, State, Zip	Code)
	id 2 sho ith and 27 is m			nson/wi		1	370	l Modra er Spri	d Way	2091	2.5		
ā,	s 1 and 2 should be filed within 72 hours after death with the Marylan fer Health and Mental Hygiene. If Health and Mental Hygiene a natural, or items 23a or 28a-f show filem 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be mailified at		20a. Method of Dis	position		20b. Place	of Dispo	esition (Name of matory or other place	ce)	Date		ition - City or To	wn, State
Ê	Page ient o nt: If ry or			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State (y)			coln Ce		2/04	Brei	ntwood	. Mđ.
saltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Fi	uneral Service Licer	nsee	A >		2. Name and Addre		Hodges			
<u>מ</u>	89559		yan	rice ?	devar	dr			ver Hil			land, M	
			23a. Patt. Enter shock, or hea	the disease, or com art failure. List only	plications that caused one cause on each li	d the death. Do ne.	not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
, 1	Physician		Immediate Cause disease or condition resulting in death)	on	a. Corror	sAM.	173	promiso	sus				
	/Medical Examiner		resulting in docum	(	Due to (or as	a consequence	of):	- 000. 1	BACLLE A.	no ence			
		E.	Sequentially list co	mmediate	b. Due to (or as	a consequence	of):	J2001(0)	112200-11	11761-21			
	ansit	Examiner	cause. Enter Under Cause (Disease or that initiated event	ertying r injury	0								
<u>,</u>	be executed sician and burial-transit	Exa	resulting in death)	Last	Due to (or as	a consequence	e of):						
1/60	ite be nysicie ne bu	cal			d		<del></del>						
200	death certificate t e attending physi d for use as the t	Physician/Medic	IF FEMALE:								15		
ROX	ath ce ttend or us	lan/	23b. Was deceder		23c. If yes, outcome 1☐Live birth	2 Fetal deal		Ectopic pregnancy	у		230	<li>d. Date of delive Month</li>	ry Day Year
	0 0 0	ysic	1 ☐ Yes 2 9 ☐ Unknown		4☐ Pregnant a 9☐ Unknown	t time of death	ΣL	Other (specify) _					
ت.	res that the igned by be detact	Ph.	Part II. Dther signi	ificant conditions	contributing to death b	out not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to th	e cause of death?
g	uires 1 sign Id be	d by								1 🗆 Y	/es 2 □	No 3 ☐ Prob	ably 4 Dnknown
Ö S	The law requires that the ste has been signed by th page 2 should be detache	Completed								24a. Was		24b. Were auto	osy findings available
Y E	The law cate has I	mo									rmed?	death?/	npletion of cause of 2  No
Vital Records,		BeC	25. Was case refe	rred to medical					26. Place of Dea			123-100	
	nysici nis ce direc	ToE	examiner? 1 XYes 2	] No	Hospital: 1 ☐ Inpatie	ent 21X ER/C	outpatie	nt 3 DOA Oth	ner: 4 🗌 Nursing H	ome 5 Resid	dence 6 [	Other (Specify	<i>'</i> )
n of	ding Ph After th funeral		27. Manner of Dea	ith 5 Pending	28a. Date of Inju (Month, Da	lry 28b.	Time o	Wo		28d. Describe h	now injury	occurred	
Sio	tendi feath. tor: A the fu	catl	2 Accident 3 Suicide	investigatio 6 ☐ Could not b		445	·		Yes 2□No	296 Logotics /6	Conne a med i	Number of Rum	I Coute Number
Division	after death Director: /	Certification:	4 Homicide	determined	280. Place of in	tc. (Specify)	rarm, st	reet, factory, office		City or Tou	vn, State)	ivumber or Hura	l Route Number,
	o Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certific slely illied in by the funeral director,		29a. Certifier	1 ☐ Certifying Pi	hysicien: To the best	of my knowled	ge, deat	h occurred at the ti	me, date and place,	and due to the	cause(s) ar	nd manner as st	ated.
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in D	Medical	(Check only one)		miner: On the basis of and manner st	of examination a							
	To the within 2 To the complet	Ž	29b. Signature and	d title of certifier	n. l	THE SECTION OF A SECTION	-	29c. Licens	se number M.E.			signed (Month,	•
	5,	1	Ma	lynte	The You	le M	0			,		uary 17	
- 1	(0)		30. Name and add	dress of person who	completed cause of	death (Item 23a	) (Type,	Prin 111 Per	nn Street	, Baltin	nore,	Maryla	nd 21201
		ate	31. Date filed (Mo	nth. Dav. Year)	12: 10:0	rar's Signature							

State Registrar

DHMH 17 Rev 1/2001

JAN 2 1 2004

32. Registrar's Signature

Section 1. April 1. ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Howell Vincella **Physician** January 18,2004 5:55 A M /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 2, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F 071-26-2343 Jamaića, Director 81 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral, or Itams 23a or 28e-f show Examiner must be notified at 1 Yes 2 □ No Anne Arundel Crofton Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1482 Lowell Court 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after de il Hygiene other than "natural", or Itami 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Assistant Private 6 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental I is marked Bradford Elsada Williams 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Importent: If Item 27 is n
eny injury or other traum Shirley Tracey Holmes (Daughter) 937 Pleasant Hill Lane Bowie, MD20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Jan.23,04 Clinton, Maryland 20735 21. Signature of Suneral Service Licensee 22. Name and Address of Facility Jordan Funeral Service, Nr. 20019 Washington, 4001 Benning RD, NE Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Atherosclerotic Heart Disease Years /Medical Due to (or as a consequence of): Examiner Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Physician: The law requires that the death certificate be executed Hypertensive Heart Disease Years and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ģ ed binods History Of Strokes 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No death. Accident 2 after death Director: 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the th 29c. License number 29d. Date signed (Month, Day, Year) ္ and 10 COIKES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane Suite 222 Bowie, MD Rakesh Arora, MD 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2004 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	GORI H	-TIATIA	For 1 State	State of Ma		d / Depa		of He	alth ar		ental Hyg	iene	2001	ns	250
			Registrar		-	Cei	incate	יוט די	Calli	1	2. Date of Dear	eg. No.	400		of Death
	Physicia	an	Decedent's Name (First, Middle, Las		D.(OMD					Í	Month	Day	Year	3. Time	
1	/Medic		GREGORY		IMOND	· · · · · · · · · · · · · · · · · · ·				_	January	1	2004	23:0	9 <sup>M</sup>
1	Examin	er	4a. Fecility Name (If not institution, give	street and number)		}	4b. City, T	fown, or L	ocation of (	Death		4c. (	County of Dea	ath	
			Prince George's H					Cheve		( Class 1 -			ince (	George'	s
	Funeral		5. Social Security Number 6. Social Security Number 1	ex 7. Age DXM 2□F 46		st birthday)	If Under 1 Months	Days	If Under 24 Hours	Min.	3. Date of Birth (Month, Dey	Yeer)	9. Bi	thplace (Stete	or Foreign
1.5	Director		5//-/8-//12	<b>A</b> 20. 40		Yrs.					4 29	195	7   MA	RYLAND	
	pu 🖈		Usuel Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside	City Limits
	eho e ho	_	111111111111111111111111111111111111111		-										s 2 No
	8a-f	ctc	MD PRINCE (	GEORGE'S	8	EAT P			-						
	within 72 hours after death with the Maryland ene. Then "naturel", or flems 23a or 28a-f ehow the Madical Examiner must be notilled at	Director	10e. Street and Number				10f. Zip (				1		en of What C	ountry?	
	23a		6304 SEAT PLEASA					0743					S.A.		
	e de la companya de l	Funeral	11. Marital Status	12. Was Decedent Ended Forces?		i. 13. V	Vas Decede f Yes, speci	ent of Hisp fy Cuban,	panic Origin Mexican, F	n? (Spec Puerto Ri	ify Yes or No- ican, etc.)	1	<ol> <li>Race - Am Black, Wh</li> </ol>	erican Indian, ite, etc.	
92	or i	Y.	1X Never Married 2 ☐ Married	1 ☐ Yes 2X No If Yes, Give	0		Yes 2	<b>X</b> No	Specify:				Specify:	BLACK	
ğ	Jours Jours	d by	3 Widowed 4 Divorced	Year or Dates:	4										
Ϋ́	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced (Give life. L	lent's Usual kind of work	Occupati k done du	ion <i>ring</i> most o	of working	7	16b. Kin	d of Business	s/Industry	
2	hen ne	du	Elementary/Secondary (0-12)	College (1-4or 5+	-)	AIR C						PRI	VATE		
N	filed v Hygie other t		12th 17. Father's Name (First, Middle, Last)			AIR O	ONDII				First, Middle, I				
2	be find by dot	Be	CLARENCE D. HAMM						JULIA	CAR	PENTER	Maideri S	oumame)		
3	should be filed within 72 hours after death with the Marylar nd Mentle Hygiene. Ind Mentle Hygiene. In marked other then "naturel", or liems 23a or 28a-f show marked other then "naturel", or liems 23a or 28a-f show unatic event, the Medical Examinat must be notified at	မ													
Maryland 21215-0036	2 2 2		19a. Informant's Name/Relationship (7 JEANNE A. CARPEN			196. Mailin	g Address CHODE	ISLA	ND AV	ENUE	Route Number N.E. V	väšfi	ington	, DC 20	0002
	and lealth m 27 her tr				Taoh Die										
0.0	of H H ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Cel	ace of Dispo metery, cren	natory or oth	her place)		Da				r Town, State	ATT.
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		`4 Donation 5 Other (Specify		HA	RMONY				-23-				MARYLAI	עמ
at	permit. Depart Import Import eny inj		21. Signature of Funeral Service Licen	see / /7		22	. Name and	Address	of Facility	J. B	. JENKI	INS	FUNERA	L HOME	
	99729		X.D. Yarsh	all							LANDOVI		MARYLA	ND 2078	85
н			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	plications that caused tone cause on each line	the death.	Do not ente	er the mode	of dying,	such as ca	ardiac or	respiratory arre	est,		Approxim Interval B	ate etween
	Physician		Immediate Cause (Final disease or condition								-015		TF.	Onset an	d Death
	/Medical		resulting in death)	Due to (or as a	conseque	ence of):		. 1766	74127C	)0~ (ii)	7 13	0 103			
138	Examiner														
Mr.	E 200 (47)	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	conseque	ence of):		-							
	uted d ansit	Examiner	Cause (Disease or injury	C											
Ć.	exectin and rial-tr	Exa	resulting in death) Last	Due to (or as a	conseque	ence of):									
760,	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	cal	(	d											
<b>68</b>	g phy as th														
ŏ	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			les .					2	3d. Date of de	elivery	
m	death a atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at t			Ectopic pre Other (spe						Month	Day	Year
P.O. Box	the oy the	nys	9 Unknown	9□ Unknown											
	signed by det	by Physician/Med	Part II. Other significant conditions c	ontributing to death but	t not resul	tting in the ur	nderlying ca	use given	in Part I.		23e. Did tot	acco us	e contribute t	o the cause o	f death?
Records,	puire n sig										1 □ Ye	s 2 🗆	No 3□P	robably 4	Jonknown
Ö	w requir been s should	lete									24a. Was a	n	24h. Were a	utopsy finding	is available
Be	has has	Completed									autops	y ned?	prior to death?	completion of	cause of
B		e Co	25. Was case referred to medical						20 51		1 -	2 □ No □	1 🖳 10	s 2 No	
Vita		60	examiner?	Hospital:		0/0		Other			Check only on				
o	무 유 등	. To	27. Manner of Death	1 Inpatien	/	R/Outpatien 28b. Time of					5 Reside			ecity)	
o	ding h. Afte fune	tlor	t Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м	Bc. Injury a Work? 1 ☐ Ye	s 2 No			,,			
S	Attending Ph er death. rector: After th by the funeral	lica	3 Suicide 6 Could not be		rv - At hon	ne farm stri	net factory				f. Location (St	reet and	Number or B	Tural Route Nu	ımbar
Division of	or A after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	)					City or Town	, State)			
_	Hospital or Attending is 4 hours after death. Funeral Director: After tely filled in by the funer	C	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of	f my know	dedne death	occurred a	t the time	date and r	place an	d due to the ca	use(s) s	and manner a	s stated	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in It	edical		niner: On the basis of and manner state	examination	on and/or inv	restigation,	in my opir	nion, death	occurred	at the time, di	ate and p	place, and du	e to the cause	o(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (Mon	th, Dey, Year)	1
	- s + ō		NO18 TO P	M. Chil	1	MP		(	O.C.M	.E.		anua	ary 18	. 2004	
0	(1)		80. Name and address of person who	completed cause of de	ath (Item)	23a) (Tyne	Print)							, 2001	
	6		MANGATA A	KURFU	(			Stre	et, B	alti	more, M	lary.	land 2	1201	
	Sta	te	31. Date filled (Month, Day, Year)	2. Registra		ure									
	Registr		JAN 2 3 2004	Elecus	J.	4000									

			For State	State of Ma		d / Depa	artme		lealth and		/giene	2006		159
			Registrar  1. Decedent's Name (First, Middle, La	st)			unce	110 01 1	Journ	2. Date of D	Reg. No	),	3. Time of D	
12	Physici	an	Jeanne M. Imbria							Januar	Da	, 2004	4:40	ам
)	/Medio		4a. Fecility Name (If not institution, give				4b. Ci	y, Town, or	Location of Dea			County of Death		
	CXamii	ier	Lorien Nursing an		tatio	n Ctr						arroll		
	Funeral		5. Social Security Number 6. S	Sex 7. Age		st birthday)	If Und	ler 1 Year	If Under 24 Hr	s. 8. Date of B	rth Your	9. Birth	place (State or untry)	Foreign
	Director		208-07-1026 Usuel Residence of Decedent	1□M 2√2F 89	9	Yrs.	Month	s Days	Hours Min	March	2, 1	914 Penr	isylvani	La
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City	
	Mar Mind	tor	Maryland Carroll		Moun	t Airy	У						1 Tes	2 No
	or 28	lre	10e. Street and Number					Zip Code			10g. Ci	tizen of What Cor	untry?	
	th wi	a	713 Midway Avenu	e			2	1771			USA			
	within 72 hours after death with the Maryland ene. Then "natural" or items 23e or 28e-f ehow na Medical Exeminer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Dec	edent of H	ispanic Origin? (	Specify Yes or N rto Rican, etc.)	0-	14. Race - Amer Black, White		
9	or it	y FL	1 Never Married 2 Married	1 Tes 2 A	10			2 X No				Specify: Whi		
ğ	ural',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:										
7	"nat	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	kind of 1	sual Occupa work done o use retired	durina most of we	orking	16b. K	(ind of Business/l	ndustry	
2	withir sne. then	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)	Sales		use remed	7		Med	ical		
2	be filed v ital Hygie id other t	ပိ	17. Father's Name (First, Middle, Last	*)				T	18. Mother's Na	me (First, Middle				
ลา	ntal and o	Be	Hayden James Sei							eth King				
Ē	should be filed within 72 hours after death with the Marylar and Mental Hygiene. and Mental Hygiene. a marked other than "natural", or itams 23a or 28a-f show marked other than "natural", or itams 23a or 28a-f show umatic event, it a Medical Examinat must be notified at	Į,	19a. Informant's Name/Relationship			19h Mailin	o Addre	es (Street :	<del>-</del>			or Town, State, Z	in Code)	
Baltimore, Maryland 21215-0036	2 2 2		Ryan J. Imbriale/	, .	i		-			MD 2109		or rown, olate, 2	p C000)	
ď.	1 and Health Iem 27		20a. Method of Disposition	0	20b. Pla	ace of Dispo	sition (A	lame of		Dete		ocation - City or 1	own, State	
٥	Pages nent of int: If its		1 ☐ Burial 2 🖾 Cremation 3 [		Met	ropol	patory o Ltan	Crem	atory,	10/0/		andria,		
	it. Partme		* 4 □ Donation 5 □ Other (Special Service Lice	-	1	22	Name	and Address		18/04	Co	11ins Fu	1 II	
Ba	permit. Departr Imports any inj		EM	Scool	0							r Spring		
	57 - Sec.		23a. Part 1. Enter the disease, or con	aplications that caused	the death.							r Spring	Approximate	701
ε			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.				3.				Interval Between Onset and De	
	Physician /Medical		disease or condition resulting in death)	Congest			ail	ure					months	
W <sub>1</sub>	Examiner			Due to (or as a Coronary			l cion						<del>4</del> 1	
out.	News S	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			LSEa	5 <b>e</b>					months	
	nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	COPD									months	
	execu n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):							MOHEND	
760,	te be executed ysician and ie burial-transit	cail	•	d										
89	ificati g phy as the			- U										
Вох	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of deliv	ery	
ň	death e atte d for	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at				pregnancy (specify)				Month	Day Ye	ar
о. О.		hys	9 Unknown	9□ Unknown										
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death bu	ut not result	ting in the ur	nderlying	cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of dea	ath?
ğ	w require been sig should b									1 🗆	Yes 2	□No 3□Pro	babiy 4 ∰Un	known
Vital Records,	s bee	Completed								24a. Was		24b. Were aut	opsy findings av	ailable
Ä	0 - 0	mo								auto perf	omed?	prior to co death? 1 ☐ Yes	ompletion of cau	use of
ta	ician: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place of De	ath (Check only		10103	21,140	
	Attending Physician: If death. ector: After this certific by the funeral director.	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital:	nt 2 E	R/Outpatien	t 3 🗆 l	Othe Othe				6 □Other (Speci	ifv)	
Ö	ding Physi h. After this c funeral dir		27. Manner of Death	28a. Date of Injur (Month, Day	y Year) 2	28b. Time of Injury		28c. Injury Work		28d. Describe				
0	tendin leath. tor: Aff the fur	atio	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, , ,	injury	М		Yes 2 □ No					
Division of	i or Attend after death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At hor	ne, farm, stre	et, fact	ory, office		28f. Location (		nd Number or Run	al Route Numbe	er,
ā	s after al Dire	Cer			(,,						m, otate	'/		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa-	hysician: To the best of miner: On the basis of and manner sta	examination	ledge, death on and/or inv	occurre	ed at the tim on, in my op	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s date and	and manner as a place, and due to	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and market sta			2	9c. License	number		29d. Da	te signed (Month,	Dav. Year)	
	F ≱ F 8			01000								ary 18,		
	2		30. Name and address of person who	phe MD	nath /li 1	22a) (T 1		D0053	150	•	- anu	41 y 10,	2004	
			Shakunmala Gupta					/FD	OIX DO:-	D ** ===				
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re /		,		BALTIM	ORE,	MARYLANI	)	
	Registi		JAN 21 20		na	19	11	acks	/					

State of Maryland / Department of Health and Mental Hygiene 03860 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10:05 a M Lillie Louise Joyner January 21, 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Genesis Eldercare-Layhill Center Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 85 1918 Director 409-32-5286 May 7, Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show traumatic avent, the Medical Examiner must be notified at 1 TYes 2 StNo Directo Maryland Prince George's Largo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 20774 USA items 23a 9715 Summit Circle, Apt. 2E death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specity: Black 3 

Widowed 4 

Divorced ear or Dates: "netural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department Store 12 Clerk ould be filed v Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Payne U.T. Sandridge 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9715 Summit Circle Apt. 2E, Largo, MD 20774 Cheri J. Koger/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 22 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Brodley xmi MD 20901 500 University Blvd. W. Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure To Thrive Months **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Exam resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No this uneral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending 1 XNatural within 24 hours arrest To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 January 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta M.D. 2401 Research Blvd. Suite 330, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 23 2004 sall Registrar

			1 - State Registrar AMEND#26per	MD1/23/04BMW,M	laryland 1600	d / Depa <i>Cer</i>	rtment of H	lealth and Death		Reg. No.	2001	, 03861
	Physici /Medic		1. Decedent's Name (First, Middle Edmund N. Jones						2. Date of De. Month 1-12-	Day	Year	3. Time of Death 9:00 P. M
	Examir		4a. Fecility Name (If not institution Casey House	i, give street and number,	)		4b. City, Town, or Rockvill		th		County of Dea	th
4 44 4	Funeral Director		5. Social Security Number 460-68-4423	6. Sex 7. A	ge (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year)		thplace (State or Foreign puntry)
	ryland		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	the Ma 28e-f	recto	MD Montgo	mery	Beth	nesda	10f. Zip Code			10g. Citiz	zen of What Co	1 Yes 2X No
	23a or	ral Di	4801 Fairmount	Ave. Apt.	#607		2081			U.S.		
036	72 hours after death with the Maryland natural; or items 23a or 28e-f ahow Jical Establine Frant bu notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Marr. 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces  1 23 Yes 2 If Yes, Give Year or Dates:	?   No	1	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2⊠ No	ispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		I4. Race - Ame Black, Whit Specify: V	
1215-0036	be filed within 72 hours after death with the Marylan dat Hygiene. Id thygiene. Id other than "natural", or items 23s or 28e-f ahow or other than "natural", or items 23s or 28e-f ahow event, it is Medical Examilitation and	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or	5+)	(Give life. L	lent's Usual Occup kind of work done o OO NOT use retired Gement	ation during most of wo			nd of Business	
Maryland 21	id be filed ental Hygic ked other c evant, II	To Be Co	17. Father's Name (First, Middle, Noverta Jones	Last)			,	18. Mother's Na	ame (First, Middle,			
lary	2 shour and Miles I is mar	-	19a. Informant's Name/Relations	· · · ·			g Address (Street	and Number or F	Rural Route Numbe			
ore, l	permit. Pages 1 and 2 should be fit Department of Health and Menial H important: If Item 27 is marked out any injury or Ather treumsalic even once.		James B. Jor  20a. Method of Disposition 1		20b. Pla		Fairmousition (Name of natory or other place		#60/ Bet		a, MD 2	
Baltimore,	nit. Pag artment ortant: I injury o		*4 □Donation , 5 □ Other (S)	pecify)	Ar1		n Nationa . Name and Addres		20-04		ington,	VA
Ra	Dep de la company de la compan		> Dendu	En Wil		1	1800 New	Hampshi:	re Ave.,	Silv		ing, MD 2090
	Physician /Medical Examiner		23a. Part1. Efter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 1 year							
a a	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as								
<b>68760</b>	icate be physicia s the bu	edical		d								
O. Box	death certil e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			2	3d. Date of del Month	ivery Day Year
ecords, P.	as this	þ	Part II. Other significent condition	ns contributing to death l	but not resul	Iting in the un	derlying cause give	en in Part I.				o the cause of death?
ĭ	The ate h	Completed							24a. Was autop perfo 1 □ Yes	rmed?	24b. Were au prior to death? 1 \( \subseteq Yes	topsy findings available completion of cause of 2 No
Vital H	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2015	D/O	Oth-		ath (Check only o		¥	Hogaica
Division of	or Attending Physicien: ifter death. Director: After this certific in by the funeral director,	ation: To	27. Manner of Death 1 ⊠Natural 5 ☐ Pendin 2 ☐ Accident investig	gation		R/Outpatien 28b. Time of Injury	28c. Injun Worl		28d. Describe h			city) Hospice
DIVIS	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 200. Flace of In	ijury - At hor itc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or Au	iral Route Number,
	e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier 1 💢 Certifyin (Check only one)	ig Physicien: To the best Examiner: On the basis of and manner s	of examination	vledge, death on and/or inv	occurred at the timestigation, in my of	ne, date and plac pinion, death occ	e, and due to the ourred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To th To th	Me	29b. Signature and Itle o certifier	<u> </u>	M	. 1	29c. License			29d. Date	signed (Monti	h, Day, Year)
	P		30. Name and address of person	who completed cause of	death (Item	23a) (Type, I	D356	35		1-1	3-2004	
			Joseph Kaplan,	6001 Muncas	ster M	ill Ro	l. Rockvi	-	20850			
	Sta Registi		JAN 23		trar's Signati	Jy	porks					

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	•	Cei	rtificate of Dea	th	Reg.	No.	UJUba
		1. Decedent's Name (First, Middle, La	ist)			2. Da	e of Death	Day Yeer	3. Time of Death
Physicia /Medic		OLIV	TE PACE	JOHNSON				0, 2004	3:45 P M
Examin		4a. Facility Name (If not institution, gi	re street and number)		4b. City, Town, or Locati	ion of Death		4c. County of Deat	h
		MONTGOMERY GI			OLNEY		a of Righ	MONTGO	
Funeral Director		5. Social Security Number 6. 412-05-8989 Usual Residence of Decedent	Sex 7. Age (In 1 M 2 X F 95	yrs. last birthday) Yrs.	Months Days Hou	rs Min. (Mo	e of Birth onth, Day, Ye RCH 15		nplece (State or Foreign untry) NNESSEE
illed within 72 hours after death with the Maryland Hygiene Hydiene Hydiene 13a or 28a-f show ant, the Medical Evarurer rivet to motified at		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
1	tor	MD. MONTGON	ŒRY		SILVER SPRI	ENG			1X Yes 2 □ No
or 28	Director	10e. Street and Number	•		10f. Zip Code		10g.	Citizen of What Co	untry?
23a (		13909 BETHPA	AGE LA.		20906	5		U.S.A	•
or items 23a or 28a-f	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic f Yes, specify Cuban, Mex	Origin? (Specify Ye lican, Puerto Rican,	s or No- etc.)	14. Race - Ame Black, White	
be lied within 72 nous also losativetin the maryal tal Hygiens do other than "natural", or itams 23a or 28a-1 shot event, the Medical Examinatinations to exemt, the Medical Examinations of the indifficial at	by F	1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No <i>Spe</i> e	city:		Specify:	HITE
natural', idical End		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupation	most of working	166	. Kind of Business/	
- Med	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during r DO NOT use retired)	most of working			
matic event, the Marie	Con	12			OWNER			RESTAUR	ANT
0 7 >	Be	17. Father's Name (First, Middle, Las			18. M	other's Name (First,		,	
should ind Men s marks umatic	7	WILLIAM	PACE	10h Maili		ANNIE	F.	ALLEN	F- O- 4-1
d 2 st th and 7 is n traun		19a. Informant's Name/Relationship			ng Address (Street and Nu				
1 and Health em 27 other tr		ELIZABETH N. TI 20a. Method of Disposition		Ob. Place of Dispo	sition (Name of	Date		LING, PID.	
permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked any injury or other traumatic e		1 Burial 2 Cremation 3 Cremation 3 Other (Spec			natory`or other place)	 z  1_21_200	1/4	O TWEDDAT E	MD
artme orten injur		21. Signature of Funeral Service Light		22	RS CREMATORY  Name and Address of Fa	acility	## T	RIVERDALE	
Departr Departr Importe any inju		>2/M/Cha	mbruad M	100091 5	HAMBERS FUNE 801 CLEVELAN	ERAL HOME ND AVE F	& CREI	MATORIUM, ALE, MD.	P A 20737
777		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nolications that caused the						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CEREBRO V	A SCITT AR	ACCIDENT			1	Onset and Death 24 HOURS
/Medical		resulting in death)	Due to (or as a cor		ACCIDENT				24 HOURS
Examiner		Commentally list and dising	h						
- =	ner	Sequentially list conditions, if any, leading to immediate the conditions of the con	Due to (or as a cor	nsequence of):					
physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c						
cian a		resulting in deathly cast	Due to (or as a cor	nsequence ot):					
physic the t	Medicai	•	_ d						
attending pl	-	IF FEMALE:	23c. If yes, outcome of pro-	egnancy			- 11	22d Date of deli	
attendi for use	Physician	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No	1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
y the cr	ysie	1 ☐ Yes 2 🖎 No 9 ☐ Unknown	9□ Unknown	0.000					
ures mar me de signed by the a Id be detached f	by PI	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause given in Pa	art I. 23	e. Did tobac	co use contribute to	the cause of death?
quires n sign	q pe	CORONARY VAS	CULAR DISEASE			h	1 ☐ Yes	2 □ No 3 □ Pro	obably 4 X Unknown
I he law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed	HYPERTENSION				24	a. Was an	24b. Were au	topsy findings available
sician: The law certificate has t irector, page 2 s	Ho					10	autopsy performed Yes 2 <b>X</b>	l? death?	2 No
	O	25. Was case referred to medical			26. P	lace of Death (Chec		10 100	22110
the Hospital or Attending Physician: The A hours atter death that A thous safer death the Funeral Director: After this certific appletely filled in by the funeral director,	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: Inpatient	2 ER/Outpatien	at 3 DOA Other: 4	Nursing Home 5	Residence	e 6 □Other (Spec	city)
ng PI fter th		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injury at Work?	28d. De	scribe how i	njury occurred	
Vitendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not	he		M 1 Tes 2				
or Atl fter d yirect in by	Certification:	4 Homicide determine		At home, farm, str pecify)	eet, factory, office	28f. Lo	cation (Street y or Town, S	t and Number or Ru tate)	rai Route Number,
pital ours a eral [		200 Contine VI Continues	hydigien. To the best of m	r knowlodgo, dosti			10 th	- (-)	
Hos 24 hc Fund stely f	edicai	29a. Certifier  (Check only 2 Medical Execute)	hysician: To the best of my miner: On the basis of exa- and manner stated.	mination and/or in	vestigation, in my opinion,	e and place, and due death occurred at the	e time, date	e(s) and manner as and place, and due	to the cause(s)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and mainter states.		29c. License numb	oer	29d.	Date signed (Month	n, Day, Year)
-3+3		Bennett ma	ruson MD		D4760	)		TAN 20	2004
5		30. Name and address of person who		(Item 23a) (Type.	D47682			JAN. 20,	2004
			RISON, M.D.		LNEY-SANDY S	PRING RD.	, OLNE	Y, MD. 20	832
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	/				
Registr	ar	JAN 22	2004 Sener	0	Sparks				

DHMH 17 Rev 1/2001

			1100001	State of Marylar	nd / Den:	artmeni	t of H	ealth a	and Me	ental Hy	niene			
			1 - For State						LITICI IVIC			2001	. 0.9	969
			1 - State Registrar AMFND#23a(h)pe	MD1/20/2004,EMA	I,McCoci	incate	O OI L	Jean		2. Date of De	Reg. No.	<u> </u>	3. Time	of Death
	Physici	an								Month	Day			
	/Medic		John Leonard Johns 4a. Fecility Name (If not institution, give s			4h City	Town or	Location of		Januar		, 2004 County of De		1.)
	Examin	er	11966 Andrew Stre					2004,017						
			5. Social Security Number 6. Sex		last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Bi		ontgome 9.B	irthplece (State	or Foreign
4	Funeral Director			M 2□F 82	Yrs.	Months	Days	Hours	Min.	(Month, Da larch	17	1921 Pe	nnsy1va	nia
			Usual Residence of Decedent			1							-	
	ylan	,	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation							10d. Inside	-
	a-f s	cto	Maryland Montgome	ry Wh	eaton								) ALI TE	s 2 No
	or 28	Director	10e. Street and Number			10f. Zip	Code				10g. Citi	zen of What (	Country?	
	within 72 hours after death with the Maryland ene. than *natural', or items 23e or 28e-f show fa Mudical Exaction mast be notified at	ai	11966 Andrew Stree	t			0902					ed Sta		
	r deg	Funeral	11. Walkar States	<ol> <li>Was Decedent Ever in L Amed Forces?</li> </ol>	J.S. 13.	Was Deced If Yes, spec	dent of His orly Cubar	spanic Orig n, Mexican,	gin? (Spec , Puerto R	ofy Yes or No lican, etc.)	^	14. Hace - An Black, Wh	nerican Indian, lite, etc.	
36	or II	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give WWII Year or Dates:		1 ☐ Yes 2	2 <b>∑</b> No	Specify:				Specify: W	hite	
8	hour	d b	15. Decedent's Edu		16a Dece	dent's Usua	I Occupa	tion			16h Ki	nd of Busines	s/Industry	
<u>.</u>	n 72	Completed	(Specify only highest grade	e completed)	(Give	kind of wor DO NOT us	rk done d	furing most	of working	g		niture	Q11104511 y	
2	withi ene. than	шc	Elementary/Secondary (0-12)	College (1-4or 5+)	Fore							inishi	ng	
о О	be filed natal Hygie of other went, I		17. Father's Name (First, Middle, Last)		1010	man		18. Mother	r's Name	(First, Middle	, Maiden	Sumame)		
an	d be antal ked c	To Be	Not Available					Ursul	la Ma	iden N	lot A	vailab	1e	
Maryland 21215-0036	should ind Men inarke umatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address						r Town, State,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may njury or other traumatic event, if a Medical Exactinating the notified at ance.		Gary R. Johnson/So	n	11966	Andr	ew S	Street	t, Wh	eaton,	Mar	y1and	20902	
Baltimore,	Hear Hear		20a. Method of Disposition	20b.	Place of Dispo	osition (Nam	ne of	e)   T	I anua	rv 21.	20c. Lo	cation - City o	r Town, State	1 a n d
0L	Pages nent of h ant: If its		1 X Burial 2 ☐ Cremation 3 ☐ P  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Gar	cemetery cree te of h neterv	leaven	1		200	4	2110	er spr	ing, ma	iryianu
₫	ortar injur	i	21. Signature of Funeral Service License	96	_22	2. Name an	d Addres	s of Facility	Robe	rt A.	Pump	hrey F	uneral	Home/
å	permit. Departr Importa any inji		1 SIRST	MO	1 346   RC	ckvil ckvil	le,	Inc. Maryl	land	20850-	2805	omery	uneral Avenue	
16 <u>1</u>	1 t.		23a. Part1. Enter the disease, or compli	ications that caused the dea									Approxim Interval B	ate
	Dhysisian		shock, or heart failure. List only or Immediate Cause (Final		. 1 ! . 1 . 7	·							Onset and	Death
}	Physician /Medical		disease or condition resulting in death)  Acute Myocardial Infarction  Due to (or as a consequence of): Coronary Art. Dis., S/PCARG										Termin	laı
þ	Examiner			Coronary Art. I	Dis., S/	FCABG <del>sease</del>	<b>1</b> -							
- 6		e	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as a consec		beabe								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events											
o î	exec in an	Exa	resulting in death) Last	Due to (or as a consec	quence of):									
760,	te be executed ysician and te burial-transit	cai		J										
<b>6</b> 8		led												
ŏ	h cer andin use	Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		☐Ectopic pro	egnancy				1	23d. Date ol d	_	
.O. Box	deatl	icia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4 Pregnant at time of a		Other (spe			<del>.</del>			Month	Day	Year
Ö	t Ihe by th tache	hys	9 🗆 Unknown	9LJ UNKNOWN										
ري دي	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	y P	Part II. Other significant conditions cor	tributing to death but not re-	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco u	ise contribute	to the cause of	death?
Vital Records,	w require been sig should b	Completed by	Hypertension							10	Yes 2	XINo 3□F	Probably 4	]Unknown
00	s been s shoul	olet	Generalized Arteri	osclerosis						24a. Was		24b. Were a	autopsy finding completion of	s available
æ	The lav te has age 2	E o								perfo	ormed?	death?	s 2 No	04430 01
ta	un: tifica tor, p	0	25. Was case referred to medical					26. Place	of Death	(Check only				
	Physician: The la r this certificate has stal director, page 2	OB	examiner? 1XX Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DO	A Othe	9E 4 □ Nur	rsing Hom	e 5 <b>∑</b> Resi	idence (	6 □Other (Sp	ecify)	
0	g Ph er th	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 2	8c. Injury Work	at	28	d. Describe	how injur	y occurred		
0	Attending in death.	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(, 22)	,,	М		res 2□N	No					
Division of	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str	reet, lactory	, office		28	I. Location (			Rural Route Nu	mber,
	s after some	Certification:		,	-77							· 		
	bour hour uner			sician: To the best of my kni ner: On the basis of examina										(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely lilled in by the funeral	Medical	one)	and manner stated.	anon and/or in				oodanat					(-)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11 0	1,7	29c	, License	number			29d. Dat	e signed (Mor	nth, Day, Year)	
	4341		Search	· Xemple	We.	5	D121	21			Janua	ary 19,	2004	
	911		30. Name and address of person who co											
			George F. Śengstac		Ferra				ton,	Maryla	ind 2	0906-4	/09	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Degistrar's Sign	ature &	100	uks	/						
	0.000	11 1	LAKIN CE II C.UU	4 h 1 /	-									

			For State Registrar	State of N	Maryland / Depa	artment of H			2001.	03861				
	Dhysia	ion.	Decedent's Name (First, Middle,			inioato or i		Reg. 2. Date of Death Month	Day Year	3. Time of Death				
- 5	Physic /Medi	cal	JANE MARIE JAR  4a. Facility Name (If not institution.			4h City Town or	Location of Death	JANUARY	14, 2004 4c. County of Death	10:45 A M				
1	Examir	ner	ST VINCENT de	•	•	FROSTBU			ALLEGANY					
	Funeral Director		5. Social Security Number 348–26–4869	6. Sex 7. A 1 ☐ M 2 🏋 F	ge (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Cou	place (State or Foreign intry)				
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	nation		ULY 8, 19						
	Maryla -f sho	tor	Maryland Montgo	morr						10d. Inside City Limits 1 ☐ Yes 2√ No				
	or 28e	Director	10e. Street and Number	mery	Silver S	10f. Zip Code		10g.	Citizen of What Cou	ntry?				
	sath w		9727 Mount Pisg	ah Road #16		209	~ ~		SA 14. Race - Ameri					
920	be filed within 72 hours after death with the Maryland Ital Hygiene. d other then "naturel", or Items 23e or 28e-f show event, the Medical Exart act rust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	Armed Forces	? ] No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto I	cry Yes or No- Rican, etc.)	Black, White					
21215-0036	72 ho "natur	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa	luring most of working	16b	. Kind of Business/Ir					
2121	f within liene. r then	omp	Elementary/Secondary (0-12)	College (1-4or	Teach	DO NOT use retired,		D.,	blic Scho	010				
nd	be filed tal Hygie d other event,	Be C	17. Father's Name (First, Middle, L		Ticacii		18. Mother's Name	(First, Middle, Maid		OIS				
Maryland		ပ	Frank I. Wehrle		10b Mailie	ag Addrage (Street a		heresa Sa	ler Ty or Town, State, Ziu	- 0-4-1				
	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		Nancy A. Jackson		1				y or rown, state, 211 1 y e • Marvla					
Baltimore,	Pages 1 and the port of Height II from the properties of the prope		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from State	20b. Place of Dispo	sition (Name of matory or other place	D.	ate 20c.	Location - City or To	own, State				
Balti	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service L	Cole	F1	Name and Addres	s of Facility Collins	Funeral H						
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	nly\one cause on each	ed the death. Do not ent line.	er the mode of dying	, such as cardiac or	respiratory arrest,	or oprain	Approximate Interval Between				
	Firysician /Medical		Immediate Cause (Final disease or condition resulting in death)  End Stage Circlosis  Due to (or as a consequence of):  Severe Hypatric Encappolopolity  1 year											
ı	Examiner		Sequentially list conditions,	b. Sen	re Hepal	ic Enc	sphaloj	saltry		1 years				
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):									
oʻ	cate be executed ohysician and the burial-transit		that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):									
8760,	cate be executed chysician and the burial-transit	dicai		d										
Box 6	death certifics e attending ph of for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	erv				
P.O. B		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Ectopic pregnancy Other (specify)			Month	Day Year				
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	lism		nderlying cause give	n in Part I.		o use contribute to the	ne cause of death?				
Division of Vital Records,	• - 5	Completed	Throm	20 cylope	riq			24a. Was an autopsy performed?	death?	psy findings available impletion of cause of				
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death	(Check only one)						
of	.s. ib	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inj	ury 28b. Time of	28c. Injury	at 2	e 5 Residence	6 ☐Other (Specificiary occurred	y)				
sion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investiga		ay Year) Injury	Work' M 1 □ Y	? es 2□No							
Divis	s after de s Direct	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 200. Place of in	jury - At home, farm, stre tc. (Specify)	eet, factory, office	2	Bf. Location (Street City or Town, Sta	and Number or Rura ite)	l Route Number,				
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	one)	and manner s		estigation, in my opi	nion, death occurre	nd due to the cause d at the time, date a	(s) and manner as si nd place, and due to	ated. the cause(s)				
<b>)</b>	To the To the complet	Σ	29b. Signature and title of certifier	H. Chilan		29c. License	353	í	Date signed (Month,					
	LU		30. Name and address of person w	ho completed cause of	Pennsylve	enial Av	e, cun	rbeilan	R, MDS	11502				
10000000000000000000000000000000000000	Sta Registr	_	31. Date filed (Month, Day, Year)  JAN 2 0	32. Regist	rar's Signature	pach	·'							

	* *		For State Registrar	(First Middle		aiyia		artment of F rtificate of I			eg. No. 200	3. Time of Death
	Physicia /Medic Examin	al	John	E .	Jennings give street and number,	)		4b. City, Town, or Temp1	Location of Dea	Januar	Day Yea	04 1:30PM
	Funeral Director		5. Social Security No. 577-50- Usual Residence of	8556	5. Sex 7. Ag 1 🖾 M 2 🗆 F	ge (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 1936	irthplace (State or Foreign Country) Wash., DC
U Z IZIO-UUSO filed within 72 hours after death with the Maryland	r 28a-f show	irector	10a. State  Md •  10e. Street and Num	10b. County		10c. C	ity, Town or Lo	cation  ole Hill  10f. Zip Code	Ls	10	ng. Citizen of What (	10d. Inside City Limits 1 X Yes 2 □ No
after death wit	ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multified at	/ Funeral Director	3411 29  11. Marital Status  1 □ Never Marrie	ed 215 Marrie	12. Was Decedent Armed Forces	?		2074  Was Decedent of Hi f Yes, specify Cuba  □ Yes 2⊠ No		Specify Yes or No- rto Rican, etc.)	United S	nerican Indian, ite, etc.
ithin 72 hours	ne. han "natural", e Wedical Exe	Completed by	3 ☐ Widowed  (Speci	15. Decedent's fy only highest	Year or Dates:	5+)	16a. Deced (Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired	ation	orking	6b. Kind of Busines	-
nd 2 should be filed within 72 hours aft	e do	To Be Cor	17. Father's Name (	First, Middle, La				river		me (First, Middle, M	Priv daiden Sumame)	ate
s i a	of Health and fitem 27 Is m r other traum	30	20a. Method of Disp	Will:	s/sister	20b.	Temp	g Address (Street a 29th A 1e Hill sition (Name of natory or other place	s, Md.		City or Town, State,	
permit. Pages 1 ar	Department o Important: If any injury or once.	1	1 4 □ Donation  21. Signature of Fur	5 ☐ Other (Spe			dar Hi	. 11 Cem .  . Name and Addres	1/1 s of Facility H	odges &		
1	lysician Medical kaminer	er	Immediate Cause (i disease or condition resulting in death)	trailure. List or Final	omplications that cause hy one cause on each li a.  Due to (or as b.  Due to (or as	a consec	quence of):	er the mode of dying			st,	Approximate Interval Between Onset and Death
ate be executed	hysician and the burial-transit	icai Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in that initiated events resulting in death) L		c	a consec	quence of):					
Attanding Physician: The law requires that the death certificate	by the attending phatached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	nonths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	aldeath 3⊡	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
quires that	gne be d	þ	Part II. Other signifi	cant conditions	s contributing to death b	ut not res	sulting in the un	derlying cause give	n in Part I.	- 0	_	o the cause of death? robably 4 □Unknown
l or Attanding Physician: The law requires t	cate has page 2	Completed	25. Was case refere							24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of s 2 2 No
nding Physicia	= 福	To B	examiner?  1 Yes 2 X  27. Manner of Death  1 Natural  2 Accident	10	28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing I	ath (Check only one Home 5 Residen 28d. Describe how	ce 6 □Other (Spe	ocify)
Hospital or Atta		i Certification;	3 Suicide 4 Homicide	6 Could not determine	ed 286. Place of Inj building, et	c. ( <i>Specii</i>	(y)			City or Town,	ŕ	
To the Hos	within 24 ho To the Fun completely i	Medicai	29a. Certifier (Check only one)  29b. Signature and t	Medical Ex	Physician: To the best aminer: On the basis of and manner sta	ted.	ation and/or inv	estigation, in my op	inion, death occi	urred at the time, dat	e and place, and du	e to the cause(s)
1		-	30. Name and addre	ss of person with	no completed cause of d	oath /ltor	n 22a) /Tuna 5	W 2	1/6+		1/16/	MD10852

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10 Day Physician 1 2004 2:40 P /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON FUTURE CARE PINE VIEW NURSING HOME If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth Month, Day, 11 30 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** GEORGIA 1 □ M 2/□ F 84 577-36-1199 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Show rthen "natural", or Items 23a or 28a-f shov the Madical Examiner oust be cotified at 1 Yes 2 No PRINCE GEORGE'S Director MD CLINTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20724 U.S.A. 9101 PINEVIEW LANE Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status o filed within 72 hours after do I Hygiene.

Other then "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SERVICE REPRESENTATIVE 9th marked other item 27 is marked other other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental LEE CALHOUN WILLER MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3301 SAVILLE LANE MITCHELLVILLE, MARYLAND 20721 19a. Informant's Name/Relationship (Type, Print) EVELYN WILSON/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 1-20-2004 BRENTWOOD, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YPERTENSIVE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ERTEX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 □No 9 Unknown 9 ☐Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 Yes 2 7 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Funeral 1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 onel within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of eart 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN 31. Date filed (Month, Day, Year) State JAN 2 1 2004 Registrar

		1 - For State Registrar	State of Marylar		artment of I tificate of			iene g. No. 2004	03867
Physic	ian	1. Decedent's Name (First, Middle, Last	)				2. Date of Deat Month	h Day Year	3. Time of Death
/Med		Nikolas Jospeh					Janua	•	3:42pm M
Exami	ner	4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Dea	th	4c. County of Deeth	-
		Anne Arundel Me 5. Social Security Number 6. Se		last histograf	Annapo		8. Date of Birth	Anne Aru	
Funeral Director			x 7. Age (In yrs. XM 2□ F	Yrs.	Months Days	Hours Min	. (Month, Dey,		lace (State or Foreign try)
		Usuel Residence of Decedent			2		Januar	y 13,2004 Ma	aryland
ehow		10a. State 10b. County		ty, Town or Lo	cation			1	0d. Inside City Limits
Ba-f	octo	MD Prince G	eorges Bo	wie					1 Yes 2 No
72 hours after death with the Maryland natural", or Items 23e or 28e-f ehow alcet Examirer must be notified at	Funeral Director	10e. Street and Number 3805 Early Glow L	ano		10f. Zip Code		10	0g. Citizen of What Coun	•
s 23	eral	11. Marital Status	12. Was Decedent Ever in U	C 12.1	20716		Specific Ven as No	United Stat	
r Item	Ë	William Status  William Status  2 ☐ Married	Armed Forces?	.3.	Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Bleck, White,	
el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 2☐XNo	Specify:		Specify: B1a	ack
72 hours "natural",	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	lent's Usual Occup	ation	drina	16b. Kind of Business/Inc	fustry
·= - #	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)	,g		
		0 17. Father's Name (First, Middle, Last)		N/A		10 Mothor's No	me (First, Middle, M	da idaa Cuma ma)	
d la b	Be C	Lerome Demetrius	Jackson				i Brown	raiden Sumame)	
E B E E	2	19a. Informant's Name/Relationship (T)		19b. Mailin	n Address (Street			City or Town, State, Zip	Code)
nd 2 lith a 27 Is		Lerome D. Jackson					,Bowie,MI		0000)
of Healt fitem 2 r other		20a. Method of Disposition	20b. F		sition (Name of natory or other place			20c. Location - City or To	wn, State
		1 N Burial 2 □ Cremation 3 □ F  * 4 □ Donation 5 □ Other (Specify)	Menioval IIOIII State		Mem Park	1	4-04	Landover,MD	)
permit. Pag Department Important: I any injury o	1	21. Sixtamre of Funeral Service Licens					ope Funer	al Homo	
205 2		palixe m	Cano		2617 Pe	nn.Ave S	.E. Washi	ngton DC 20	020
Examiner be executed by bhysician and sthe burial-transit	ical Examiner	Sequentially list conditions, any loading to annuable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)	uence of):				, ,	
the death certify the attending iched for use as	Physician/Medic	in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3 aeath 5	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
sign d be	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	derlying cause giv	en in Part I.	23e. Did tob	acco use contribute to the s 2 No 3 ☐ Proba	e cause of death? ably 4 Unknown
The ate har page	Completed	25. Was case referred to medical						ed? prior to comdeath?	sy findings available pletion of cause of
Physician: This certifical ral director, p.	o Be	examiner?	lospital:	EB/Outpeties	2□ DOA Oth	ar:	ath Check onl one		
Jing After fune	tion: To	27. Manner of Death 1 ■ Natural 5 □ Pending	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun	at Nursing F	ome 5 Resider 28d. Describe hov		)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre			28f. Location (Str. City or Town,	eet and Number or Rural State)	Route Number,
To the Hospital or Al within 24 hours after of To the Funeral Director models of the fulled in by	edical C	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the car irred at the time, da	use(s) and manner as sta te and place, and due to	ited. the cause(s)
To the within 2 To the	Me	29b. Signature and title of certifier	01/1		29c. License	number	29	d. Date signed (Month, D	Pay, Year)
		1 Suman N	-dellen	DO.	HY	2727		-	
		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	rint)	^	, ,	anuary 5 Md 21401	16,2004
S.	4	Suzanne Rind Neis 31. Date filed (Month, Day, Yeal)	ch bo PAMC 32. Registrar's Signa	Loui V	Neuhical	PKuy. A	ND Apoli	5 Ma 21401	
Sta Regist	40	JAN 2 1 2004	Keeler K	Soul	2)		*		

State of Maryland / Department of Health and Mental Hygiene

				Otate of W	iai yiaira 7	Certifica			nona (1)	Reg. No. 2	101	Π	3860
	DI		1. Decedent's Neme (First, Midd		-				2. Dete of De Month		Yeer		e of Death
	Physici /Medic		Mary	Louise		ackson			1	ry 14,2		9:	00 PM
	Examin		4a Fecility Neme (If not institution Heartland Hear			lphi		4b. City, Town, or I Ade 1		,	of Death	orge	es.
	Funeral		5. Sociaf Security Number	6. Sex 7. A	ge (In yrs. lest b	irthdey) If Und	der 1 Year	·		th v Vest)	9. Birthpl	ace (Sta	nte or Foreign
	Director		578-40-5284 Usuef Residence of Decedent	1□M 2∏F	71	Yrs. Month	s Deys	Hours Min.	July 11	7, 1932	Car	″So oIi	nth na
	yend w		10a. Stete 10b. County	1	10c. City, To	wn or Location					10	d. fnside	e City Limits
	Men af en	ğ	Maryland Prince	e George's		Clinto	on					1 <b>X</b> 2 Y	res 2□No
	or 28	Director	10e. Street end Number			10f. 2	Zip Code			10g. Citizen of \		ry?	
	ath w	ra	9608 Beverly A					0735			SA	an Indias	
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Merylend f Heelth and Mental Hygiene. If Heelth and Sa or 28s-f show tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mar  3 ☑ Widowed 4 □ Divorced	If Yes, Give 23	? No			dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify			1
5-0	72 ho	ete	15. Deceder (Specify only highe	nt's Education est grade completed)	16	a. Decedent's Us (Give kind of t	sual Occup work done	petion during most of word)	king	16b. Kind of Bu	usiness/Ind	ustry	
121	vithin hen	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT	use retire	ø Housewii	_	Priva	tα		
d 2	iled v Hygie ther t		17. Fether's Name (First, Middle,	Last)				18. Mother's Nan					
an	ould be filed v Mental Hygie mrked other t	To Be	Unknown					Thomaser	na	Miles			
ary	2 should and Men is market	-	19a. Informant's Neme/Relations	ship (Type, Print)				and Number or Ru			Stete, Zip	Code)	
Σ	1 and 2 Heelth a em 27 Is other trace		Gregory G. Jack	kson (Son)	9	608 Beve	erly	Avenue (	Clinton,		735		
ore	of Hee		20e. Method of Disposition  1X☐ Buriel 2 ☐ Cremetion	2 □Removal from State	comet	of Disposition (A ery, cremetory o	lame of r other ple	ce)	Date	20c. Location -	City or Tov	vn, State	•
Ē	Peges ment of ant: If Ite		4 □ Donation 5 □ Other (5	Specify)	3	1/21/04	Clinto	n, MD					
Baltimore,	permit. Peges Depertment of Important: If It any Injury or once.		21. Signature of Funeral Service	Dicensee		uss of Fecility Jou ng Rd., M	dan Fun VE Washi			, In 0019			
		$\neg$	23a. Pert1. Enter the disease, or shock, or heart failure. List	rest,		Approxir Interval	mate Between						
A Park	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	<sub>e</sub> Arteri	osclero	tic Card	liova					Onset a	nd Death
		Jer			Due to (or as a	a consequence o	r):				!		
	rificata be executed ng physician end es the buriel-trensit	Medical Examiner	Sequentially list conditions,	b	Due to (or as a	consequence o	f):						
90,	e exe	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	,									
68760,	cata b	dica	that initieted events resulting in death) Last		Due to (or as e	consequence o	f):				1		
	£ 50	Me		d									
Box	eath cer attendin I for use	Physician/	Death Other death, and another	and contribution to doub	but not requiting	in the underlying	Called Gi	van in Part I	23h Did i	obacco use co	ntribute to	the cau	se of death?
Ö	of the de by the a	hys	Part II. Other significant condition	bus contributing to death	out not resulting	in the underlying	y cause gi	on in arci.		Yes 2□No			
S, D	as thet igned b	by P	Dementia								1		
Records,	iaw requiras thet tha death ce as bean signed by the attendi o 2 should be datached for use		End Stage Ren	al Disease					24a. Was perlo	an autopsy rmed?	ava	ilable pri	sy findings ior to
ec	law r	Completed			-						of d	eeth?	of cause
al F	cate has		Peripheral Va		ase					res 2∭ No	1 🗆	Yes 2	2□ No
Vital	Physician: The this certificate ral director, pages	o Be	25. Wes case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Hospitaf	: a 🗆 E D (C	Note at inst. OF	DOA Oth		th <i>(Check only o</i> ome 5 ☐ Resid		or /Caasih		
ō		-	27. Manner of Death	28a. Dete of Inj	ient 2 ☐ ER/C	. Time of	28c. fnju Wo			now injury occur		,	
ion	Attending is death.	를 I	1. Natural 5 ☐ Pending 2 ☐ Accident investi	ng (Month, Di	ey rear)	Injury M		Yes 2 □ No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Plece of it	njury - At home, etc. (Specify)	farm, street, fact	ory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural	Route N	lumber,
	To the Hospital o within 24 hours aff To the Funeral DI completely filled in	edical C	29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis of end manner s	of exemination e	ge, death occurre and/or investigation	ed et the ti on, in my o	me, date and place opinion, death occu	, and due to the orred at the time,	cause(s) and ma date and place,	inner as sta and due to	ited. the caus	3e(s)
	within To the	Me	29b. Signature and title of certifie	er 0 1	. 1 =		9c. Licens	se number		29d. Date signe	signed (Month, Day, Year)		
			1 / Smil	andel	Ire	n	DC	1852		Janu	ary 1	5, 2	2004
	(6)		30. Name end eddress of person										
_	0		Paul A. DeVore,			ry Road	Hya	ttsville,	MD 20	781			
	Sta	te	31. Date filed (Month, Day, Year,		trer's Signature	land.							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARY ELIZABETH JONES **Physician** 13,2004 MA00:8 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renee's House Assisted Living Facility Prince George's Bowie Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthptace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1□ M 2🔀 F 220-07-4530 81 February 12,1922 Maryland Director Usual Residence of Decedent 10d. tnside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show the Medical Expressor must be notified at 1 **2**Yes 2 □ No Prince George's Bowie Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12323 Whitehall Drive 20715 USA 238 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or flems 11. Marital Status Black, White, etc. unknown 1 □ Never Married 2 □ Married filed within 72 hours after Specify: Black 1□Yes 2ENo Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or othar traumatic event, Ite Maule 2008. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ashberry Jones Ida (maiden name unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Blount/Guardianship Specialist 5012 Rhode Island Ave. Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 01/22/04 Alexandria, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4111 Pennsylvania Ave.Suitland, MD 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician Arrhythmia Sudden /Medical Due to (or as a consequence of). Examiner Emphysema, advanced Decades Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a consequence off Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð peq 1 ☐ Yes 2 🛣 No 3 Probably 4 □Unknown Senile dementia page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funerel Director: / 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2 D22780 1/16/2004 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Peter M. Schissler, M.D. 7500 Greenway Center Drive, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) State JAN 2 0 2004 Registrar

			1- For Amend Item #2	State of Maryland 20b per fh G82	8 2ZP	artment of H	lealth and M Death	lental Hygic	ene g. No. 2004	03870
	Physici	an	Decedent's Name (First, Middle, Last)     Otho T	homas	Tarr	att, II	т	2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give s		Juli		r Location of Death	January	19,2004 4c. County of Death	1:08 p M
5	Examir	ier	Anne Arundel Medic			Annapo1			Anne Arund	e1
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1		place (State or Foreign
	Director		219-48-4793 Usual Residence of Decedent	56	Yrs.			Oct 18,		hington DC
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation			1	Od. Inside City Limits
	a-fsh	ctor	Maryland Anne Arur	ndel Lot	hian				-	1 Yes 2 □ No
	or 28	Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cour	ntry?
	eath v	eral	71 Patuxent Mobile	Estate 12. Was Decedent Ever in U.S	12.1	20711	ispanic Origin? (Spe	orfu You or No.	USA 14. Race - Americ	oon Indian
(0	ifter d	Funeral	11. Marital Status  1 \( \sum \) Never Married 2 \( \sum \) Married	Armed Forces? 1 XYes 2 ☐ No	'	f Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)	Black, White,	
ğ	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 67-69		1 ☐ Yes 2 <b>X</b> CNo	Specify:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Ita Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of worki	ng 16	6b. Kind of Business/In	dustry
7	l within iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		c Manager			Grocery	
	e filed al Hygie I other vent, II	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ylaı	should be and Mental s marked o umatic eve	10	Otho Thomas Jarrat					ouise Rh		
Maryland	d 2 sh ih and 7 is m traum		19a. Informant's Name/Relationship (Ty)						City or Town, State, Zip	
	s 1 and Health tem 27 othar tr		Melissa Jarratt/Wi 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	01018		ian, MD 201 oc. Location - City or To	
altimore,	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ R 1 4 □ Donation 5 □ Other (Specify)			am Vet. C			heltenham,	MD
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance if fiem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service License  Myelin T. Klobe	at M01322	22 Fo	Name and Addres		1 Bladens	sburg Rd, 1	MD Brentwood
	The law requires that the death certificate be executed <b>XII</b> te has been signed by the attending physician and <b>XII</b> be detached for use as the burial-transit <b>XII</b> in <b>XII</b>	dical Examiner	23a. Par1. Enter the disease, or compli- modiate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					Interval Between Onset and Death
.O. Box 6	res that the death certifics igned by the attending pl be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetel o 4 □ Pregnant at time of dea 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions con	tributing to death but not resul	ting in the ur	nderfying cause give	en in Part I.		cco use contribute to the	e cause of death?
		Completed						24a. Was an autopsy performe	24b. Were autoprior to condeath?	osy findings available inpletion of cause of
	sician: Th certificete rector, pag	) Be	25. Was case referred to medical examiner?	ospital:	700	Othe	26. Place of Death			
Division of	ding Ph h. After th funeral	ıtlon: To	27. Manner of Death  Natural 5 Pending 2 Accident investigation		P/Outpatien 28b. Time of Injury	28c. Injury Work	4 LI Nursing Hon	8d. Describe how	be 6 Other (Specify injury occurred	"
	in the contract of	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	(Check only 2 Medicel Exemin	icien: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	estigation, in my op	pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	e no		29c. License	number 5/CJ	29d.	Date signed (Month, I	Day, Year)
	(F)		30. Name and address of person who cor	mpleted cause of death (Item 2	23a) (Tvne- I	Print) -	7101		1.1109	
	(5)	10	31. Date filed (Month, Day, Year)	7001 b	1-d.	Par	. Kway	Annapol	S OM, E	1401
H	Registr	_	JAN 2 2 2004	Glock K	hood	E)				

DHMH 16 Rev 6/95

T

2

の大い

JACKSON

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Α NELLIE KERR JAN 19 2004 /Medical 30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 XF 373-20-5984 Director 85 Feb.24,1918 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits sust be natified at Director 1 ☐ Yes 2 ☑ No Fairfax 288-1 McLean 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 6251 Old Dominion Dr.,#123 Funerai USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian the Madical Examiner: Black, White, etc. within 72 hours after Yes 2X No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 □XVidowed 4 □ Divorced natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tour Guide Private Industry Pages 1 and 2 should be filed nent of Health and Mental Hygid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be it of Health and Menta injury of other treumatic 2 Bessie Leach Clarence Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Macy / Daughter 490 Plaza Estival, San Clemente, CA., 92672 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of once. \* 4 ☐ Donation 5 ☐ Other (Specify) Northern Va. Crematory 1-22-04 Arlington, Va. 22. Name and Address of Facility Arlington Funeral Home 21. Signature of Funeral Service Licensee (Wufte 3901 N. Fairfax Dr., Arlington, Va. 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sause. Enter or Johning Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate Division of Vital 1 Tes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospitel within 24 hours a To the Funeral E the Hospitel completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/oy/nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 20 0102201465 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER TODD R. LAROCK MC LCDR USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 23 2004 oaks Registrar

			State of Maryland / Department of Health and in Certificate of Death		eg. No. 200	6 03873
	<u>.</u>		Decedent's Name (First, Middle, Last)	2. Dete of Dee Month	th Dey Year	3. Time of Death
J.	Physici /Medic		Marion D. Kleinsorge	January		11:23 AM
	Examir		4a Fecility Name (If not institution, give street and number)  4b. City, Town, or U	ocation of Death	4c. County of De	eth
			Randolph Hills Nursing Home Whea		Montgor	nery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  OF 0.5 173.7 1 Months Days Hours Min.	8. Date of Birth (Month, Day	, Year) 9. B	irthplece (State or Foreign Country)
	Director		365-05-1737   10 M 225   89 Yrs.	March 1	, 1914 Ne	ew York
	pur *		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	sho	5	MD Montgomery Kensington			1 XYes 2 No
	280-1	ect	10e. Street and Number 10f. Zip Code	Τ,	0g. Citizen of Whet 0	Country?
	h with	Funeral Director	3616 Littledale Road #109 B		United St	
	deat	ner	11. Maritel Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	
Baltimore, Maryland 21215-0020	filed within 72 hours effer death with the Maryland Hygiene. ther than "natural; or terms 23a or 28e-f show ent, the Medical Examiner must be notified at	Completed by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒No If Yes, Give Year or Dates:	o moan, etc.)	Specify:	White
5-0	72 hc	e e	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use retired)	kina	16b. Kind of Busines	s/Industry
121	ithin	du	Elementary/Secondary (0-12)   College (1-4or 5+)		Woodward a	and Lothrop
2	be filed withing the Hygiene.  d other then event, the H	Ö	12 Sales Representati	ve		
and	8 - 8 ×	Be			Maiden Sumame)	
3	12 should be and Mental is marked o raumatic eve	ို		ilable		
Ma	0 8 8 5		19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Ru   106 Mallard Lane, LaP			
ore,	of Health item 27 i		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery crematory or other place)		20c. Location - City o	r Town, State
Ē	Page International		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Gate of Heaven Cemetery	January 22. 2004	Silver S	Spring, MD
3alt	permit. Pages 1 Department of F important: If ite any injury or of		21. Signature of Funeral Service Lica say	Vol Fune	ral Home,	10 East Deer
	0.0 = 0		Park Drive, Gaithe	MD 20877		
1000			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final			Oriset and Death
	Examiner		disease or condition e. Progressive Dementia			Years
		ē	Due to (or as a consequence of):			
	tificete be executed ig physician and es the burial-transit	Examiner	Sequentially list conditions,  Due to (or as a consequence of):			
90,	e exe	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
68760,	ohysic the b	edical	that initiated events resulting in death) Last Due to (or as a consequence of):			
			d			, 
Вох	etten for u	ian				
P.O.	thet the death cert ed by the ettendin deteched for use	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?
	The law requires thet the death cer ate hes been signed by the ettendin page 2 should be deteched for use		Chronic Obstructive Lung Disease	1 □ Y	es 2∐No 3⊠I	Probably 4 Unknown
rds	w requires to been signer should be	d by		24a. Was a		Were autopsy findings
of Vital Records,	w red	Completed		perform	ned?	available prior to completion of cause of death?
æ	The law ete hes page 2	E		1 7 Y	s 2⊠No	1 ☐ Yes 2 ☐ No
tal		Bec	25. Was case referred to medical 26. Place of Dea	th (Check only on		
<u> </u>	Physician: rthis certific rel director,	0	examiner?		nce 6 Other (Sp	ecify)
0	g Phy ter thi nerel	T:u	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		w injury occurred	
Ö	Attending in death.  Sector: After by the fune	ä	2 Accident investigation M 1 Yes 2 No			
Division	or Attendent efter deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	pitai ours erai filled	2	29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece,	end due to the ca	ause(s) and manner a	s steted
	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)  2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, d	ate and place, and du	e to the cause(s)
	To the vithin 2 To the comple	X	29b. Signature and title of certifier 29c. License number	1	9d. Date signed (Mon	
	10		Martin C Shapel 1) D08944		January 19	, 2004
	1 -	Ì	30. Name end address of person who completed caute of deeth (Item 23e) (Type, Print)			
			Martin C. Shargel M.D., 3720 Farragut Avenue, Kensing	ton, MD	20895-2110	)
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 3 2004  32. Registrar's Signature  Apauls			

DHMH 16 Rev 6/95

		Please	State of Maryland					_	e.
		1 - For State Registrar AMEND#7perFH1/	-	•	tificate of			•g. No 2 0 0	4 03874
		Decedent's Name (First, Middle, Last)	)				2. Date of Dea Month	th	3. Time of Death
Physic /Medi		Janet G.	Kol	nn			January	19, 200	
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	th	4c. County of	Deeth
		Shady Grove Hosp			Rockvil If Under 1 Year			Montg	
Funeral Director		289-26-1590	7. Age (In yrs. last) 7. Age 7	Yrs.	Months Days	Hours Min		0, 1928	Birthplece (State or Foreign Country) Onio
and		Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Lo	cation				10d. Inside City Limits
Varyl f sho	ō	D.C. N/A	Was	shing	ton				1⊠Yes 2□No
r 288	Director	10e. Street and Number	77 (3.1)		10f. Zip Code		1	0g. Citizen of Wh	at Country?
If Z 12.13-0030 filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or frams 23a or 28a-1 show ont, the Maxical Examinat must be multiled at	a D	3418 Reservoir Ro	ad N.W.		20007	•		United	States
deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
turaf.		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a Decer	ient's Usual Occup	ation		16b. Kind of Busin	ness/Industry
in 72	piet	(Specify only highest grad	e completed)	(Give	kind of work done	durina most of w	orking	700. 11.10 01 000.	,
d with giene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Atto	rney			Private	
other the	Be C	17. Father's Name (First, Middle, Last)		1			ame (First, Middle,		
Ments Ments arked	To	Ernest M.	Goldric			Rose		insberg	
perillinoie, Mal yialia A 12 13 0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any igly or other traumatic event, the Madical Enantires must be nutitied at once.		19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailir 3418 . ]	ng Address (Street Reservoir	and Number or F	Rural Route Number W •	r, City or Town, St	ate, Zip Code)
t and tealth om 27		Melvin L. Kohn (Hu	20b Plac	e of Dispo	Reservoir ngton, D. sition (Name of			20c. Location - Ci	ty or Town State
or of the		1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State Choo	neterry, crem	hatory or other place ke Cremat	orv 1-1		Beltsvil	-
Deartified Separtment of mportant: If it iny injury or o		* 4 □ Donation 5 □ Other (Specify)  21 Signature of Funeral Service Licens	-	I					
Depre any song		1 Cui	5	R	app Funer	ral And S	Cremation ilver Spr	Service	s 20910
		23a. Part1. Enter the dis se, or comp shock, or heart failure. List only o	tions that a used the leath.	Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	S and sacrime.						Onset and Death
/Medical		resulting in death)	Due to (or as a conseque	nce of):					2 days
Examiner		Sequentially list conditions.	b						
pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):					
ou, be executed icien and burial-transit	хаш	that initiated events resulting in death) Last	c Due to (or as a conseque	nce of):	-				
rou, te be executed ysicien and te burial-transit	al E			. ,					
ficate ficate p phys	1 0		0.						
The COLOS, T.O. BOX 00/ The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal d		Ectopic pregnancy	,		23d. Date of	
death	sicia	in the past 12 months?	4 ☐ Pregnant at time of dea 9 ☐ Unknown		Other (specify)			Month	Day Year
at the	Phy	9 Unknown					OZ- Didas		uto to the course of death?
res th	by	Part II. Other significant conditions co	ntributing to death but not result	ing in the ui	nderlying cause giv	en in Parti.	236. Did to		ute to the cause of death?  Probably 4 Unknown
w requires t been sign should be	Completed							-	
has by 30 2 s	mpf						24a. Was a autops perfori	sy prio	re autopsy findings available or to completion of cause of lith?
VICAL FICE SICION: The law S Certificate has b lirector, page 2 s	e Co	25. Was case referred to medical				00 Place of P	1 ☐ Yes	-,	Yes 2□ No
Or VICA Physician: rthis certifical ral director,	To Be	evaminer?	Hospital: 1. Inpatient 2 E	3/Outpatien	at 3 DOA Oth	ac	eath (Check only or Home 5 Reside		(Specify)
g Phy g Phy er this		27. Manner of Death		8b. Time of		v at		ow injury occurred	
Attending ar death.  ector: Atterby the function	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Buy Your)	тцагу		Yes 2 □ No			
r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number n. State)	or Rural Route Number,
urs af			<u> </u>			Real ALL CO	400000000000000000000000000000000000000	5.77. ESST	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical		sician: To the best of my knowliner: On the basis of examinatio and manner stated.						
o the	Me	29b. Signature and title of certifier	and manner states		29c. Licens	e number	2	9d. Date signed (I	Month, Day, Year)
<b>⊢</b> ≯ <b>⊢</b> 0		Jon 8h	> M.O		D60	557	7		2004
7		30. Name and address of person who co	ompleted cause of death (Item 2	3a) (Type,	Print)				1, 2004
		Leo Shue M.D. 9	901 Medical Ce		Drive Roo	ckville,	MD 2085	U	
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re G	Sporks	1			
Regist	rar	JAN 23 201	14	/-	//				

			1 - For State Registrar	State of Marylar	•	artment of F			iene	2004	038	375
			1. Decedent's Name (First, Middle, Last)	)		-		2. Date of Deat	h Day	Vess	3. Time of	Death
н	Physicia		ROSA Z. KRAFT					JANUARY		2004	3:15	РМ
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Dea	ath	4c. (	County of Deeth		
		•	12320 DALEWOOD DRI	VE		SILVER S	PRING		MOI	NTGOMERY		
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs.	last birthday,				Year)	9. Birthp	lace (State o	r Foreign
	Director		088-05-8741	JM 21€0 F	5 Yrs.	Monsio Bays	1100.0	AUGUST 1	, 19	908 POLA	NĎ	
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or L	ncation				1	0d. Inside Cit	tv I imits
	anyla shov	<u> </u>			•						1 Tes	•
	188-1 188-1	Director	MARYLAND MONTGOMER	KY SILV	VER SPI	10f. Zip Code			On Citiz	en of What Cour	atry?	
	with ti	D I	10e. Street and Number								itt y :	
	hours after death with the Maryland ture!; or Items 23e or 28e-f show a Exercitive traint to inclifted at	Funeral	12320 DALEWOOD DRI	12. Was Decedent Ever in U	18 13	20902	lispanic Origin?	(Specify Yes or No-	S. A	A . 4. Race - Americ	an Indian	
	ltam Itam	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 ☒ No	,	If Yes, specify Cuba	an, Mexican, Pue	erto Rican, etc.)		Black, White,		
320	irs af	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: WHI	TE	
21215-0036	be filed within 72 hours after death with the Marylar dia Hygiene.  I al Hygiene.  I dether than natural; or Itams 23a or 28a-f show other than natural Exercities at event, the Miculcel Exercities in a set for inclined at		15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kin	d of Business/In	dustry	
212	within 72 ene. than nat	ple	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of w d)	rorking				
21	d wit	Completed		2	HOME	1AKER			WN I	HOME		
9	e filed al Hygid other vent, ti	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, I	Maiden S	Sumame)		
<u>a</u>	should by nd Menta marked matic e	ပ္	ISAAC Z	ZWERNER			FRIEDA			ARBITER		
Maryland	of Health and Ment of Health and Ment I Itam 27 is marked r other traumatic	8 1	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ng Address (Street	and Number or i	Rural Route Number	City or	Town, State, Zip	Code)	
2	Health tam 27		DANIEL KRAFT/SON				TH WAY,	POTOMAC,				
altimore,	Tital T		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F		Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or To	own, State	
Ĕ	permit. Pages Department of I Important: If its any injury or o		*4 □ Donation 5 □ Other (Specify)		S ISRA	EL CONG.	CEM.01/	09/2004 W.	ASHI	NGTON,	D.C.	
ä	pparti		21. Signature of Funeral Service Licens	ee .		2. Name and Addre		G MEMORIAL	СН	APETS T	NC	
<u>m</u>	70 F 9 9		1 (Manda ) U	dewa	11:	<u> 170 ROCKV</u>	<u>ILLE PIR</u>	<u>KE, ROCKVI</u>	LLE	, MD 208	52	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the dea ne cause on each line.	ith. Do not en	ter the mode of dyin	ng, such as cardi	ac or respiratory arre	est,	:	Approximate Interval Bett Onset and D	ween
)	Physician		Immediate Cause (Final disease or condition	a HYPERTENSION	N						Oligot and a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
	Examine		Sequentially list conditions,	b								
	sit ad	Examiner	Sequentially list conditions, cause. Enter Underlying	Due to (or as a consec	quence of):							
	ate be executed nysicien and he burial-transit	каш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):							
760,	cien cien			240 (0) 43 4 00 100	4401100 017.							
00	physi s the b	dicai		d								
9 ×	death certifica e attending ph id for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv			( <del>)                                     </del>		2d Data of dalling		
Вох	attene for us	ian	in the past 12 months?	1 Live birth 2 Fet	al death 3	□Ectopic pregnancy □ Other (specify)	/		1	3d. Date of delive Month		Year
o.	the de	ysic	1 ☐ Yes 2 🎇 No 9 ☐ Unknown	9☐ Unknown	death 3		<del></del>					
_	The law requires that the de ate has been signed by the a page 2 should be detached f	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not re	sulting in the t	inderlying cause giv	en in Part I.	23e. Did tot	oacco us	se contribute to the	ne cause of d	leath?
ds,	w requires that been signed I should be det							1 □ Ye	s 21X	No 3□Prob	ably 4 🗆 L	Jnknown
Ö	requ been shoul	Completed						24a. Was a	n	24b. Were auto	ney findings	available
ğ	has has	g.						autops perforr	y ned?	prior to co death?	mpletion of ca	
<u>=</u>								1 ☐ Yes		1 🗆 Yes	2 No	
Vital Records,	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:	7.50.0	Oth		eath (Check only on		T0:: (0 ::		
ō	유유	. To	1 ☐ Yes 2 ☑ No	1 ☐ Inpatient 2 ☐	28b. Time of		4 ∐ Nursing v at	Home 5 X Reside			γ)	
on	ding Ph h. After th funeral	tou	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		rk? Yes 2 ∐No					
Division	or Attending after death. Director: Afte I in by the fune	fica	3 Suicide 6 Could not be	286. Place of injury - All	home, farm, st	reet, factory, office		28f. Location (St	reet and	Number or Rura	I Route Num	ber.
<u>S</u>	E Die ge	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Town	n, State)			
	spita nours neral		29a. Certifier 1 Certifying Phy	rsician: To the best of my kn	lowledge, dea	th occurred at the tir	me, date and pla	ce, and due to the ca	ause(s) a	and manner as s	tated.	
	To the Hospital or At within 24 hours after of the Funeral Directompletely filled in by	edicai	(Check only 2 Medical Exami	inar: On the basis of examin and manner stated.	ation and/or in	nvestigation, in my o	ppinion, death oc	curred at the time, d	ate and	place, and due to	the cause(s	)
	To the Hospital within 24 hours to the Funeral completely filled	M	29b. Signature and title of certifier	(h )		29c. Licens		2	9d. Date	signed (Month,	Day, Year)	
	15		1 Expense	(1)		(13)	532		1/	19/04		
	1		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type	. Print)						
			PRAVEEN K. GUPTA,	M.D., 50 W.	EDMONS'	TON DRIVE	#202, I	ROCKVILLE,	MAI	RYLAND 2	0852	
鱫	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	Ana V	. ,					

			For State Registrar	State o	f Marylar		artment rtificate			and M		Reg. No.	7111	) 4	03	876
г	Obveisi		1. Decedent's Name (First, Middle, I	.ast)							2. Date of De. Month	Day	/ Ye	ear	3. Time of	
	Physici /Medic			Anna K.	Kurz		1				Januar		, 200	-	2:00	) P M
	Examin	er	4a. Fecility Name (If not institution, g		mber)				Location o	of Death			County of I			
	.00-1		4514 Amherst Lar 5. Social Security Number 6	1e Sex	7. Age (In yrs.	last hirthday)	If Under	thes	sda If Under 2	24 Hrs.	8. Date of Birt	_	Montgo			r Foreign
	Funeral Director		219-12-4313	1 ☐ M 2 🖾 F	80	Yrs.		Days	Hours	Min.	(Month, Da Feb. 3,	y, Year)	23 Pe	Count	ace (State of try) sylvan	ia
			Usual Residence of Decedent								100. 3,	1.7.				
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10	od. Inside Ci 1 ☐ Yes	•
	e Ma	cto	Maryland Montgo	mery		Beth	nesda									2140
	ith th	Director	10e. Street and Number				10f. Zip						zen of Wha			
	death with the Maryland ms 23s or 28s-f show rmast be notified at		4514 Amherst Lan		edent Ever in U	IS 13	Was Deced	208		nin2 (Sne	ofy Yes or No		ted S			
_	ltem Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	13.	If Yes, spec	fy Cubar	n, Mexican	, Puerto	city Yes or No Rican, etc.)		Black, \			
2	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/8		1 ☐ Yes 2	. No	Specify:				Specify:	Wh	ite	
212-0030	72 ho	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua kind of won	l Occupa	tion	t of worki	na	16b. K	nd of Busin	ess/Ind	lustry	
7	thin .	nple	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	DO NOT us	e retired)			•					
7	ygien ygien ygien ygien tr. Ing	ပ်		2		Home	emaker		10 Matha	de Nome	(First, Middle,		Home			
yland	be fill	Be	17. Father's Name (First, Middle, La	St)									Surrame			
Ž	d Mer nark natic	2	Raymond Karge  19a. Informant's Name/Relationship	(Type Print)		10h Maili	na Address	(Street a			Reische		r Town Sta	te Zin	Code)	
<u> </u>	d 2 sl th and 17 is r traur		Peter E. Kurz/So				•				idloth:	-				2
a)	1 an Heall		20a. Method of Disposition		20b. i	Place of Dispo	and the same and the			- 0	ate		cation - Cit			_
<u> </u>	y or o		1 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		State	cemetery, cre. rklawn			101	anua 200	ry 21,	Rock	ville	. м	ary1aı	nd
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-f show injury or other traumatic event, the Medical Existing in a cultified at 905s.		21. Signature of Funeral Service Life		124						Funeral					
ñ	Ded of the same		Katto	N.	M00	$198 \begin{array}{ c c }\hline 75 \\ \hline 75 \\ \hline \end{array}$	obert 57 Wis	A. E	rumpn sin Av	rey	Funeral Bethesd	. ноп .a, M	ie/ ( D 208	has:	e, Inc 3501	c. '
25	Physician /Medical Examiner prize phantal fransit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, large leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consequence of):										e ween Death			
68/6U,	98	cai	IF FEMALE:	d										-		
C. BOX	that the death certificat ned by the attending phy detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live b	tcome of pregn birth 2 ☐ Feta nant at time of d own	al death 3	□Ectopic pre						23d. Date o M <i>on</i> th		•	/ear
ras, P	sign and b	ρ	Part II. Other significant conditions	s contributing to d	eath but not res	sulting in the u	inderlying ca	use give	n in Part I.			obacco u res 2	_	te to the	e cause of dabiy 4	leath? Inknown
Hecord	(g LL	Completed									24a. Was autor perfo 1 Yes		24b. Wer prior deat 1 [	th?	osy findings apletion of c	available ause of
VItal	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o					
0	ding Physin.  After this of funeral directions.	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	10		ER/Outpatie 28b. Time o		A	4 🗆 Nu		ne 5 Resid 28d. Describe I			Specify	")	
	ding After fune	lon	1 ⊠Natural 5 ☐ Pending		of Injury th, Day Year)	Injury	M .	Bc. Injury Work 1 □ Y	?` ′es 2 □ l				,			
DIVISION	deal deal ctor: / the	Certification;	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determini	be 28e. Place	of Injury - Al h ing, etc. (Speci	ome, farm, st					28f. Location (S City or Tox			or Rural	Route Num	ber,
	To the Hospitel or A within 24 hours after To the Funeral Direct Completely filled in by	Medical C		Physician: To the saminer: On the band man												)
•	To the within To the	Me	29b. Signatur, and title of certifier	Tomak	v 90	ay, m	290	. License	number	6		29d. Da	e signed (A			/
	17		30 Name and address of person when the same and address of person when the same and	Ko Nau	se of death (Ite	1 23a) (Type,	Print)	e R	odd.	Ro	ckvill	'e, 1	nD:	201	2004 852	
İ	Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 0	2004 32/6	legistrar's Sign	ature 4	Sp	ak				/				

			1 - For State Registrar		Marylar	nd / Depa		t of H	lealth a	and M		giene Reg. No.	20	04	03877
	Physici	an	Decedent's Name (First, Middle	111	w Marak	ood Vis					2. Date of De Month	Day	,	Year	3. Time of Death
4	/Medic	al	A. F. Wh. Name of and institution	Violet Ma		ead Kii		<b>-</b> 1.27	1	-(0	Januar				5:50 A.M
	Examin	ier	4e. Fecility Name (If not institution HCR/Manor Ca	-				Town, or Theat	Location	of Death			Mon t		~~~
	Eunaval		5. Sociat Security Number			last birthday)	tf Under		If Under	24 Hrs.	8. Date of Bir		Mont		
	Funeral Director		577-94-9217 Usuel Residence of Decedent	1□M 2( <b>X</b> F	8:		Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 2	20,19	20	Jama	lace (State or Foreign htry) West ica, Indies
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. Inside City Limits
	Many Ff sh	to	Maryland Mor	tgomery		Silv	er Sp	oring	3						1XYes 2 □ No
	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28a-f show ha Medical Exeminer mast be notified at	<b>Funeral Director</b>	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of W	hat Cour	itry?
	ath wi	ral	2703 Randolp	h Road			_1	20902					ica,	Wes	t Indies
	er de	une	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Deced If Yes, spec	dent of Hi offy Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)-		- Americ , White,	an Indian, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	If Yes Give	9		1 ☐ Yes	2 <b>K</b> ) No	Specify:				Specify:	<b>B</b> 1	ack
ò	2 hou ature	ted	15. Deceden	t's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Bus	siness/Inc	dustry
215	thin 7 e. an "n Med	ple	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired,	<i>lurin</i> g mos	t of worki	ng				
2	ed wi ygien yer th	Completed	8th grade				Home	emake					omes		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depardment of Health and Mental Hygiens. Depardment of Health and Mental Hygiens Hygiens if it is marked other than "naturel", or Items 23a or 23a-f show miportant: if item 27 is marked other than "naturel", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Evantual must be notified at ance.	To Be	17. Father's Name (First, Middle, William	Last) <b>fuirhead</b>					18. Mothe		(First, Middle,		Sumame	)	
ary	and Name		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	er, City o	r Town, S	itate, Zip	Code)
Σ	and 2 Balth n 27 i		Blossom Veronic	a Doyley (	(daught	ter) 27	03 Ra	ındo1	ph R	oad;	Silver	Spri	ng,M	ary1	and 20902
ore	of Hor		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from S	20b. F	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place	9) .T		7,2004	20c. Lo	cation - C	City or To	wn, State
Ë	. Pag tment tant: jury o		*4 ☐ Donation 5 ☐ Other (S	pecify)		ort Lin			etery						ryland
Baltimore,	permit Depar Impor any in		21. Signature of Funeral Service	uch C	lem		600 K	enne	dy St	treet		Wash	ans, ingt	Inc on,D	.c. 20011
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the deat ch line.	th. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rrest,			Approximate Interval Between Onset and Death
>	Physician		Immediate Cause (Final disease or condition resulting in death)	Metas	static	Gastri	c Can	cer			-1-				Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	or as a conseq	quence of):									
		er	Sequentially tist conditions, if any, leading to immediate	b. — Due to (o	or as a conseq	quence of):								-	
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events	c											
Ö,	e exerian ar	Ex	resulting in death) Last		or as a conseq	quence of):									
8760,	ate b	dical		d			_	_		_				-	-
9 x	Attending Physician: The law requires that the death certificate be executed redeath. redeath. sctor: Atter this certificate has been signed by the attending physician and set or: Atter this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outc	ome of pream	ancy									
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live bir	th 2 Feta	it death 3□	Ectopic pro					2	3d. Date Mont		ry Day Year
P.O.	the d by the achec	hysi	9 ☐ Unknown	9□ Unknov				// —							
رب ت	uires that the de signed by the a Id be detached f	by P	Part II. Other significant condition	ons contributing to dea	ath but not res	sulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco u	se contrib	ute to the	e cause of death?
ğ	w require been signature										101	res 2[	]No 3	☐ Proba	ably 4X Unknown
Records,	law ra as be	Completed									24a. Was autop		24b. W	ere autop	sy findings available appletion of cause of
<u>=</u>	the cate h	S									perfor 1 ☐ Yes	rmed?	de	ath? ∃Yes	_
₹	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				. Othe	_		(Check only o	-			
ō	Phys r this ral dii	۲ <u>.</u>	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 UIN		ER/Outpatien 28b. Time of		A	4 <u>M</u> NU		ne 5 🗌 Resid				)
on	ding th: After	盲	1 Avatural 5 Pending		, Day Year)	tnjury	м	Bc. Injury Work 1 □ Y	? ′es 2 ⊟≀		ou. Describe i	iow intury	CCCUITO	•	
	Atter	ifica	3 Suicide 6 Could r	inad 200. Place C	of tnjury - At ho g, etc. (Specif	ome, farm, stre	et, factory	, office		2				or Rural	Route Number,
۵	tel or rs afte el Dir ed in	Certification;	Tiomicos	Dulani	g, etc. ( <i>Specii</i>	<i>y)</i>					City or Tow	m, State)			
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medicel I	g Physician: To the b Exeminer: On the bas and manne	sis or examina	owledge, death	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	nd due to the ded at the time, d	cause(s) a	and mani place, an	ner as sta d due to	ited. the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	B	1	//	29c.	License			- 1				Dey, Year)
			Islam	K	oga	Kar	M	D52	261			Janu	lary	10,	2004
_	4)		30. Name and address of person Alan R. Segal;		/			ver	Sprin	ıg, M	aryland	1 209	906		
	Sta Registra		31. Date filed (Month, Day, Year)  JAN 2 0 20	#2. Re	gistrar's Signa										

Im Sook Kim

	04-00306 MAN		For 1 State Registrar			nd / Depa		f Health a	and Mental F		2004	03878
	Physicia /Modio		1. Decedent's Name (First, Middle In Sook Ki						2. Date of Month Janua	Day	y 2004 Year	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution Suburban Hospi		i number)		4b. City, Tow Bethe	n, or Location	of Death		. County of Death	
	Funeral Director		5. Social Security Number 577-04-2631	6. Sex 1 ⋅ M 2 🖔	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under	Min. (Month,	Birth Day, Year)	9. Birthr	place (State or Foreign ntry)
	D	or	Usual Residence of Decedent  10a. State 10b. County  Md . Montgo			ity, Town or Lo			Aug. 1	.5,157		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the sor 28a-	Direc	10e. Street and Number		1_0	ETVEL D	10f. Zip Coo				tizen of What Coul	ntry?
36	ges t and 2 should be filed within 72 hours after death with the Maryland it of Heatih and Mental Hygiene. If itsm 27 is marked other than "natural", or itsms 23a or 28a-f show or other traumatic svent, the Medical Examiner must be notified at	Completed by Funeral Director	703 Buccaneer  11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 XDivorced	12. Was Arme 1 🗍 V	Decedent Ever in U d Forces? Yes 2XINo s, Give or Dates:	1		of Hispanic Or Cuban, Mexica	igin? (Specify Yes or n, Puerto Rican, etc.)	U.S	14. Race - Americ Black, White, Specify: Asi	, etc.
21215-0036	in 72 hou n "natura	pleted	(Specify only highe	1		16a. Dece (Give	dent's Usual Oo kind of work do DO NOT use re	ocupation one during mos stired)	st of working	16b. K	(ind of Business/In	dustry
d 212	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ira M		Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle)		ge (1-4or 5+)	Restu	rant Ow		er's Name (First, Mid		sturant	
Maryland	should be nd Mental marked o	To Be	Kwang Yong So	shin (Tune Print	)	19b Maili	ng Address (St		n Bok Heo er or Rural Route Nu	mber. City o	or Town. State. Zi.	p Code)
Baltimore, Mai	permit. Pages t and 2 st Department of Health and Important: if Itsm 27 ts r sny injury or other traur angles.		Juny Kyu Kim (Dr. 20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (	ughter)	20b.	7 03 Place of Dispo		er Ct.	Silver Sp Date	rings 20c. L		04 own, State
Baltir	permit. Pa Departmen Important: sny injury		21. Signature of Funeral Service  23a. Part1. Enter the disease, o shock, or heart failure. Lis	Licensee B	ell	2	2. Name and A	ddress of Facili	Phillip E	ell F	uneral S	Service 1748 Approximate Interval Between
I	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	e to (or as a conse	iple 1						Onset and Death
760,	pet is	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b>	e to (or as a conse e to (or as a conse							
O. Box 68	that the death certificate be execu ed by the attending physician and detached for use as the burial-tra	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	1	s, outcome of pregr live birth 2 Fet Pregnant at time of Jnknown	tal death 3[	□Ectopic pregn □ Other (specif				23d. Date of deliv Month	rery Day Year
ds. P	equires that the sen signed by nould be detact	by P	Part II. Other significant condit	tions contributing	to death but not re	sulting in the t	inderlying cause	e given in Part		id tobacco		the cause of death? bably 4 □Unknown
Vital Records.	The law requir ate has been s pace 2 should	completed							24a. V	utopsy erformed?	prior to co death?	opsy findings available ompletion of cause of
Vita	Physician: Th this certificate	o Be C	25. Was case referred to medic examiner? 1 ★ Yes 2 No	al Hospital:	1 ☐ Inpatient 2%	Z <b>}€</b> R/Outpatie	nt 3 DOA	Other	e of Death (Check or ursing Home 5 🗆 F		6 ☐Other (Speci	ify)
ion of		atlon T	27. Manner of Death  1 Natural 5 Pend		Date of Injury (Month, Day Year)	28b. Time of Injury 625	A 28c.	Injury at Work?	28d. Descri	be how inju	iry occurred	ear
Division	r Att ter de lrect	Certification	3 ☐ Suicide 6 ☐ Could	not be 28e.	Place of Injury - At building, etc. (Spec	home, farm, si	reet, factory, of	fice	28f. Location City or	n (Street ar Town, State		al Route Number. Silver Spring: V. USUL'TE AVE
	ospitel o hours af uneral D	Salc	29a. Certifier 1 Certify	ing Physician: 1	o the best of my kr	nowledge, dea	th occurred at the		nd place, and due to	the cause(s		

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

January 13, 2004

29c. License number

O.C.M.E.

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last,	State of Marylar	•	artment of			Reg. No. 2U	04 0387
Physicia /Medic Examin	al	ALVIN ABBY E 4a. Facility Name (If not institution, give CIVISTA MEDIC	COHNE  street and number)  CAL CENTER		•	n, or Location of Dea  APIATA  ar   If Under 24 Hrs	th	4c. County o	6;19 P of Death
Funeral Director		Usual Residence of Decedent	M 2□F 63	Yrs.	Months Da			940	Birthplace (State or Foreig Country)     MARYLAND
he Marylan 28a-f ehow cuilled at	Director	VA KING GE		ING GEO				10g. Citizen of W	10d. Inside City Limit 1 ☐ Yes 2 📉N
with t		10e. Street and Number 16476 SCHO	OLHOUSE RD			485		U.S.	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ehow or other treumatic event, the Medical Examinar roust be reciliated at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	į.		of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No to Rican, etc.)	o- 14. Race Black	- American Indian, ;, White, etc.
thin 72 ho e. en "natur Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Oc kind of work do DO NOT use re	cupation ne during most of wo ired)	orking	16b. Kind of Bus	siness/Industry
iould be filed wil I Mental Hygien Parked other thatic event, the	То Ве Соп	8TH  17. Father's Name (First, Middle, Last)	A. KOHNE	<b>T</b>	RUCK DR	18. Mother's Na		TRUCKI , Maiden Surname SNER	
nd 2 shoulth and M	-	19a. Informant's Name/Relationship (T) MARY KOHNE (SP			•	eet and Number or R LHOUSE RD			
ages 1 ar nt of Hea : If item; or other		20a. Method of Disposition 1   Burial 2XXCremation 3   F	lemoval from State	Place of Dispo cemetery, crei	sition (Name of natory or other	olace)	Date	20c. Location - C	City or Town, State
permit. Pages Department of t Important: If ite any injury or of		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Usens		22	. Name and Ad	MATORY 1/ dress of Facility AF INGS HWY			SERVICE
Physician		23a. Part 1. Enter the disease, or comp shock, or lear failure. List only o Immediate Cause (Final disease or condition resulting in death)				tying, such as cardia		rrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting an death)	Due to (or as a consec	uence of): ERTENS	TON				
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical Examiner	Sequentially list conditions, 1 any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.	uence of)r					
The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3 [	Ectopic pregna Other (specify			23d. Date Mont	of delivery th Day Year
w requires been sign should be	Completed by Pł	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause	given in Part I.	1 ☐ '	Yes 2 No 3	bute to the cause of death?  B Probably 4 Unknow  ere autopsy findings availab
n: The law icate has l r, page 2 s								ormed? de 2 A No 1	or to completion of cause o eath? ☐ Yes 2 ☐ No
Physicien: The la r this certificate has ral director, page 2	To Be	TI Tes ZINO		R/Outpatier	I 3 DOA	Other: 4 Nursing	,	dence 6 Other	
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 1	njury at Vork? □ Yes 2 □ No		how injury occurre	
rs after d al Direct led in by	Certifi	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)			City or To	wn, State)	r or Rural Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death	n occurred at the vestigation, in m	e time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, an	ner as stated.  nd due to the cause(s)
To the within 2 To the complete	M	29b. Signature and title of certifier	Juan 1	- MD	2	ense number 20629		29d. Date signed 1/6/04	(Month, Day, Year)
	ite	DR. CEORGE 1  31. Date filed (Month, Day, Year)	mpleted cause of death (Iter VATHEN 11345  32. Registrar's Signa	PEMBRO	•	SUITE 103	WALDORE	F MD 2060	3

		i iças					. ( Ll = lab =				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		For State	State	of Marylar	-		of Health a				104 0:	0000
		Registrar	t 41		Cel	rillicate	of Death		Reg		3. Time	of Death
Physicia	an	1. Decedent's Name (First, Middle,	Last)	1	oone	AM	TT		Month January	Dav	Yeer	рм
Medic	The Control	Jeorge	V .		.00110				January	4c. County o		P
Examin	er	4a. Fecility Name (If not institution,	_		1	Tako	own, or Location o ma Park			Montg		
, <u>, , , , , , , , , , , , , , , , , , </u>		Washington Adv	S. Sex	Hospita. 7. Age (In yrs.					. Date of Birth			or Foreign
Funeral Director		095-28-2938	1∰ M 2□ F	67	Yrs.	Months	Days Hours	Min.	Date of Birth (Month, Day, pr. 25,	1936	9. Birthplace (State Country) New York	
andy a		Usuel Residence of Decedent										
rylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo						10d. Inside	Sity Limits s 2 ™ No
e Ma	cto	Maryland Montgo	omery		Silver							5 2 110
ith th	Dire	10e. Street and Number		1		10f. Zip 0			10	g. Citizen of WI		
ath w	Funeral Director	816 Easley Stree					0910	0 /0	( V N .	US.	A American Indian,	
er de	nue	11. Marital Status	Armed I	cedent Ever in U	J.S. 13.	Was Decede If Yes, specif	nt of Hispanic Original of the Cuban, Mexican	n, Puerto Ri	can, etc.)		, White, etc.	
hours aft	by F	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		<sup>2□No</sup> Da <sup>Sive</sup> Dates: Unkn		1 Yes 2	No Specify:			Specify:	White	
2 hou	ed	15. Decedent's	Education		16a. Dece	dent's Usual	Occupation		1:	6b. Kind of Bus	siness/Industry	
7 nic n	pie	(Specify only highest Elementary/Secondary (0-12)	7	(1-4or 5+)	(Give	kind of work DO NOT use	done during most retired)	t of working	'			
d with	Completed	12	Comogo	(1.10.01)	F]	lorist				Floral	Design	
Vent,	Be (	17. Father's Name (First, Middle, L							First, Middle, M.		)	
Vidiro buid be file Mental Hy arked oth attic event	ပို	Walter L. Loo	nam Sr.						A. Fie			
d 2 should and 7 ie muttraum		19a. Informant's Name/Relationsh					Street and Number				State, Zip Code) ge Park, FI	32073
C, N 1 and 1 and Health em 27 ther to		Bernard Joseph	Loonam/E		Place of Dispo			Dat	a 2		City or Town, State	
S S H S H S S S S S S S S S S S S S S S		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation		n State	cemetery, crei	matory or oth	ner place)	Janua	ry 20		,	
Description Pages Department of Important: # it inportant: # i		*4 □Donation 5 □Other (Sp		Me			rematory	20			lria, Vir	ginia
partitione, intal yield A I Z I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Department of the marked other then "naturel", or items 23s or 28s-f show eny injury or other traumatic event. The Medical Event are must be notified at		21. Signature of Funeral Service L	icensee		Fi 50	rancis	Address of Facilit	ins F	uneral	Home In	oring, MD	20901
	-	23a. Pan1. Enter the disease, or o	complications that	caused the dea							Approxim	ate
		shock, or heart failure. List of immediate Cause (Final	nly one cause or	each line.	lon						Interval B Onset and	Death
Physician /Medical		disease or condition resulting in death)	a. Dun t	o (or as a conse		C	mcer				1 m	enth
Examiner				0 (01 43 4 0011301	quonec ory.							
* *	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due t	o (or as a conse	циалсь об.							
cuted od ransit	Examiner	that initiated events	С.									
ou, be executed ician and burial-transit		resulting in death) Last	Due t	o (or as a conse	quence of):							
0 0 0	lical		d									
Certificat certificat nding phy use as th	Physician/Med	IF FEMALE:	020 14				-					
death cer death cer e attendir ed for use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Fet gnant at time of	al death 3	Ectopic pre				23d. Date Mon	of delivery th Day	Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unl		death 5	Other (spe	cny)					
res that the de signed by the a be detached in	H.	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	inderlying ca	use given in Part I		23e. Did toba	acco use contri	bute to the cause of	death?
N 8 2 8	d by								1 ☐ Yes	2 No	3 ☐ Probably 4 [	Unknown
> 0 0	ompieted								24a. Was an		/ere autopsy finding	s available
The law ate has b page 2 si	E C								autopsy	ed? de	rior to completion of eath? □Yes 2□ No	cause of
VICION: The certificate rector, pag	ပိ	25. Was case referred to medical					26 Place	e of Death (	1 ☐ Yes 2 Check only one			
Of VICA Physician: ribis certific ral director,	0 0	examiner?	Hospital: 1	inpatient 2	☐ ER/Outpatie	nt 3 DO	Other		9 5 ☐ Resider		r (Specify)	
on or ding Phys. h. After this controlled	Ë	27. Manner of Death 1 Matural 5 ☐ Pending	(8.4)	e of Injury onth, Day Year)	28b. Time o	if 28	c. Injury at Work?	28	d. Describe hov	v injury occurre	ed	
SION tendin death. tor: Aft the fur	atic	2 ☐ Accident investig	ation			М	1 ☐ Yes 2 ☐	No				
DIVISION  al or Attending a after death. I Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 289. Pla	ce of Injury - At h Iding, etc. (Spec		reet, factory,	office	28	If. Location (Street) City or Town,		er or Rural Route Nu	mber,
ultal or rel Dir												
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xeminer: On the	he best of my kn basis of examin anner stated.	iowledge, deat lation and/or in	h occurred a vestigation,	it the time, date an in my opinion, dea	nd place, an ath occurred	d due to the car I at the time, da	use(s) and man te and place, a	nner as stated. nd due to the cause	(s)
To the within 2 To the complet	Med	29b. Signature and title of certifier	andine	ailitei stateu.		29c.	License number		29	d. Date signed	(Month, Day, Year)	
10		) () ((a)	1CINIA	MIL	1.12.		D-30	921	7	amila	in 20	2004
10		30. Name and address of person a	who completed ca	use of death (Ite	m 23a) (Tvpe	Print)	- 0		2 -	0.5.00	0,20	0 .
		10313 (-	Porgi	a Au	renue	#	209,	21/1	ier s	yririg	, 1702	-0702
	ate	31. Date filed (Month, Day, Year)		Registrar's Sign	nature 4	1.	rels			4		
Regist	rar	JAN 21	2004	Percent	1	apo	us					

		1 _ State	State of Marylan		artment of tificate o			ene g. No. 200	l. 0380
Physici	an	1. Decedent's Name (First, Middle, Last)	Income Combi				2. Date of Death Month	Day Year	
/Medic Examin	al	4a. Facility Name (If not institution, give so				n, or Location of Dea		20, 2004  4c. County of Dea  Montgomer	
Funeral Director		5. Social Security Number 6. Sex 053 38 1298 1□			If Under 1 Ye Months Day		. (Month, Day,		rthplace (State or Foreign country)
Maryland a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgome		, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
3a or 28	I Dire	10e. Street and Number 15908 Maple Ridge	Court	-	10f. Zip Cod			og. Citizen of What C Lited Stat	•
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or Items 23e or 28e-f show aumstic event, the Madical Exercities is set be ricitified	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin? ( uban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi SpecifyCau	ite, etc.
vithin 72 hou ne. han "natura nadical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life. I	DO NOT use ret	ne during most of wo	orking 1	6b. Kind of Business	,
filed Hygir other	To Be Col	12 17. Father's Name (First, Middle, Last) Nathan Nelson		House	ekeeper	18. Mother's Na	me (First, Middle, M Jiren	Domestic Haiden Surmarne)	
1 2 F B	_	19a. Informant's Name/Relationship (Type James F. Levy - So	n	28-35	5th Str	eet Des N	loines Io	City or Town, State,	
Demit. Pages 1 a Department of Hec mportant: If item any injury or othe		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State Uni	emetery, crer Lon Fie		etery 01/2	23/2004 R	oc. Location - City o idgewood, uneral CH	New York
permit Depar Impor any in		21. Signature of Funeral Service License	Evan	2 5	755 Cast	tlewellan	Drive Ale	xandria,	VA 22315
Pnysician /Medical Examiner	er	23a. Part 1. Enter the disease, or complication of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, than you cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consequence of the consequence)	uence of):		The such as cardie	с от техриалогу атте	St,	Approximate Interval Between Onset and Death
death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregna Other (specify)			23d. Date of de Month	elivery Day Year
The law requires that the tee has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.	23e. Did tob		to the cause of death? Probably 4 Unknown
(0	Completed						24a. Was an autopsy perform	prior to	
, <u>&gt; .01</u> 0	To Be	25. Was case referred to medical examiner?	ospital: 1 🗍 Inpatient 2 🗍	ER/Outpatier	nt 3 DOA	Other	ath <i>(Check only one</i> Home 5 🗋 Resider		ecity)Grays
eath. or: After this	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	njuryat Work? i ☐ Yes 2 ☐ No	28d. Describe how		Home
Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the fune		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify strains: To the best of my kno	/) 			City or Town,		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ter: On the basis of examina and manner stated.		vestigation, in m		urred at the time, da		e to the cause(s)
30		3) Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	-32-33	2	0/22	oy
Sta Registi		Dr. Suresh K. Gupt 31. Date filed (Month, Day, Year)	32. Registrar's Signa		Suite	220 Silve	r Spring,	MD 20902	301-681-59

					,	Cer	tificate of	Death	F	leg. No. 2	004	03	882
			1. Decedent's Name (First, Mid	Idle, Last)					2. Date of Dea Month	ith Day	Vons	3. Time of	Death
	Physici		Meade	Learmouth					January		Year 004	10:35	AM
	/Medic Examin		4e Fecility Name (If not institut	ion, give street end number	er)			4b. City, Town, or					
	LAGIIIII	ICI	Carriage Hill	Nursing Hom	e			Bethesda		Montg	gomer	У	
-	Francis		5. Social Security Number		Age (In yrs. las	t birthday)	If Under 1 Yea			1	9. Birthp	olace (State o	or Foreign
	Funeral Director		391-01-2236	1⊠ M 2□ F	92	Yrs.	Months Day	s Hours Min.	Sept. 4,	1911	II.	linois	-
	4-		Usual Residence of Decedent						1				
	de s		10a. Stete 10b. Coun	ty	10c. City,	Town or Lo	cation				1	0d. Inside Ci	ity Limits
	Mary	ō	Maryland Montg	gomery	Gait	herst	ourg					1 ☐ Yes	2 ☑ No
	288 E	Director	10e. Street end Number	-			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at		20620 Plum Cre	eek Court			2088	2		United	1 Sta	tes	
	eath Fe 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. \	Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americ	an Indian,	
_	Ter d	5	1 ☐ Never Married 2 ☐ Ma	Armod Coroo	s? □NoWorld	1 '	f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)		ck, White,		
ន្ត	rs af	by	3 ☑ Widowed 4 □ Divorce	If Yes, Give	s:War II		I□Yes 2⊠ No	Specify:		Specif	<sup>ʻy:</sup> Whit	:e	
Ş	hou tr	귷		ent's Education		16a Decen	lent's Usual Occi	upation	1	16b. Kind of B			
5	n 72 "na nalic	Completed	(Specify only high	nest grede completed)		(Give life. L	kind of work done OO NOT use retir	e during most of wo ed)	rking				
7	within iene. than "	Ē	Elementary/Secondary (0-12	College (1-4d	or 5+)		untant			Federa	al Gor	vernme	nt
2	e filed al Hygid other vent,		17. Father's Name (First, Middle	a Last)		11000	Janeane	18. Mother's Na	me (First, Middle,				
E S	8 ta 8	Be	John Joseph Le	-					ne McClu		.,		
ž	should be and Menta marked	2	-			401 44:31	1 11 (04				Canto Tio	Codel	
Ja	2000	- 4	19a. Informant's Neme/Relation					et and Number or Ri reek Cour		-			
-	end ealth n 27	- 1	Louise L. Sull	ilvan/ Niece			sition (Name of	reek Cour					
Baltimore, Maryland 21215-0020	permit. Peges 1 end Depertment of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	n 3 🗆 Removal from Sta	te 200. Plac	etery, crep	natory or other pl	morial .	Jan. 23,	20c. Location	- City or 10	wn, State	
E	Peg ment mry ury		4 □ Donation 5 🛣 Other				Park		2004 F	Rockvil	1e, M	arylar	nd
aĦ	S S S S S S S S S S S S S S S S S S S	_	21. Signature of Funeral Service	ce dice dee		22	. Name and Add	ress of Fecility RO	bert A.	Pumphre	y Fui	neral	Home/
$\mathbf{\alpha}$	88E 8 8	0	MKkm 1.	1	M00689	) K	рокуттте	, Inc. 30 ckville,	Maryland	20850-	21 y A. 2805	/enue,	
			23a. Part 1 Enter the disease, shoot or heart failure. Li	or complications that caus	sed the death.	Do not ente	er the mode of dy	ring, such as cardia	or respiratory arr	est,	2005	Approximat	e
Name .	Ohusisian		shook for heart failure. Li	st only one cause on eech	n line.						İ	Interval Bet Onset and I	
1	Physician /Medical		Immediate Cause (Final								1		
	Examiner		disease or condition resulting in death)	a Multi-							1		
		5			Due to (or a						i		
П	nsit	Examiner		Parkin	son's I						i		
	rifficete be executed ng physicien end es the buriel-transit	xar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or a	s a conseq	uence of):				1		
68760,	be e icien burie	<u>a</u>	Cause (Disease or injury	C							1		
87	phys the	edical	that initiated events resulting in death) Last		Due to (or as	s e consequ	uence of):				1		
		2		d							1		
Вох	es thet the death ce igned by the ettendii be deteched for use	Physician/											
o.	0 0	Sic	Part II. Other significant condition	tions contributing to death	but not resulti	ng in the ur	nderlying cause g	iven in Part I.	23b. Did to	obecco use co	ntribute to	the cause	of death?
P.O.	d by letec	표	Prostate Canc	er					1 U Y	es 2⊠ No	3 ☐ Prol	pably 4	Unknown
Ś	The law requires thet the ste hes been signed by the pege 2 should be deteched.	ě							-				r - r
5	v require been si should	Completed	Chronic Obstr	uctive Pulmo	nary Di	Lsease	9		24a. Was a perfor	n autopsy med?	ava	ere autopsy f ailable prior t	to
Vital Record	aw respense	Die						-				mpletion of c death?	Ause
č	The law te hes rege 2:	E							1 T Y	es 2 k No	1 🗆	]Yes 2□	No
<u>a</u>		BeC	25. Was case referred to medic	al				26. Place of Dea	ath (Check only or	ne)	<del></del>		
>	Physician: r this certific aral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2□EP	VOutpatien	t 3 DOA	ther:	lome 5□ Resid		ner (Specifi	v)	
ō	Phys r this aral di		27. Manner of Death	28e. Date of In (Month, I		b. Time of	28c. Inj		28d. Describe h				
Division	Attending or deeth.	ᅙ	1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	ding (Mohin, i	Jey rear)	Injury		∃Yes 2⊟No					
<u>S</u>	dee ctor y the	fica	3 ☐ Suicide 6 ☐ Coul	mined 200. Place U	Injury - At home	e, farm, stre	et, factory, office	)	28f. Location (S	treet and Numi	ber or Rura	Route Num	ber,
2	or lefter Olred Jin b	Certification:	4 ☐ Homicide	building,	etc. (Specify)				City or Tow	n, State)			
_	To the Mospital or Attending Phy within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	2	29a. Certifier 152 Certify	ring Physician: To the be	st of my knowle	dge, deeth	occurred at the	time, date and place	, and due to the c	ause(s) and m	anner as st	ated.	
	24 hg 24 hg Fun etely	edlcai	(Check only 2 Medica	ring Physician: To the beat al Examiner: On the basis and manner	of examination stated.	end/or inv	estigation, in my	opinion, death occu	irred et the time, d	ate and place,	and due to	the cause(s	i)
	ithin o the omple	2	29b. Signature and title of certif				29c. Licer	nse number	2	9d. Date signe	d (Month,	Day, Year)	
				1/1 /	Vac	>	D3	5579	J	anuary	19,	2004	
a i	(1)	-	- pen	- wy		/=							
1	9		30. Name end address of perso					Rothoca	la Martil	and 209	316		
	~ 1	6.4	Susan J. Mille 31. Date filed (Month, Day, Yea		strar's Signatur		rerrace	, Betheso	ia, maryi	and 200	,10		
	Stat Registra	0	JAN 2		strai s Signatur	9	Spark	2					

			For State Registrar	State of N	Maryland	d / Depa	artmer	nt of H te of L	ealth ar D <i>eath</i>	nd Mei		ene g. No. 20 (	) 4	0388	3
	Dhysiei	on.	1. Decedent's Name (First, Middle, La	st)							Date of Death Month	Day Y	ear	3. Time of Death	
	Physici: /Medic		MIRIAM	К.		LARE					ANUARY	16, 200		5:00P	М
	Examin	er	4a. Facility Name (If not institution, giv		r)		4b. City		Location of VILLE			4c. County of		OMERY	
			6111 MONTROSE ROA  5. Social Security Number 6. S		Age (In yrs. la	ast birthday)	If Unde	r 1 Year	If Under 24		Date of Birth (Month, Day,		. Birthol	ace (State or Fore	ign
	Funeral Director			☐M 2☐xF	84	Yrs.	Months	Days	Hours		(Month, Day, 1 0 / 20 / 19		Count	ng TON D	
	p		Usual Residence of Decedent		10- 01-	T					7.207.20			d. Inside City Lim	
	aryiar ahow	ž	10a. State 10b. County		10c. City	, Town or Lo	cation						10	1 □ Yes 2 ☑	
	the M	Directo	MARYLAND MONTGOM  10e. Street and Number	IERY				CKVII p Code	LE		10	g. Citizen of Wh	at Count		
	3a or	O	6111 MONTROSE ROA	D #715					20852				S.A.	,	
	death	Funeral	11. Marital Status	12. Was Deceder		S. 13.	Was Dece	dent of His			y Yes or No- an, etc.)	14. Race -			
9	be filed within 72 hours after death with the Maryland and bylgiene. Bylgiene bylgiene do ther than "natural", or itams 23a or 28a-f ahow do ther than "natural", or itams 23a or 28a-f ahow event. It a Modical Examinar must be notified at	/Fu	1 Never Married 2 Married	Armed Forces  1 Yes 2  If Yes, Give  Year or Dates	No NAV	Y '	1 ☐ Yes		Specify:	. donto i no	un, oto.,	Specify:			
215-0036	72 hours "natural", adical Exa	d by	3 Widowed 4 Divorced		: Ulikii	16a. Dece	dont's Lieu	al Oscupa	tion		1	6b. Kind of Busin		WHITE	
7	in 72 in mai	Completed	(Specify only highest gra	de completed)		(Give	kind of wo	ork done d ise retired)	uring most o	of working	'	ob. Killd of busii	1922/110	ustry	
	y with	mo	Elementary/Secondary (0-12)	College (1-4o 4	r 5+)	ACCOU	NTAN'	Γ				PRIVATE	,		
<u> </u>	e filed al Hygi I other vant. I	Bec	17. Father's Name (First, Middle, Last	)					18. Mother's	s Name (F	irst, Middle, M	aiden Sumame)			
Maryland 21	should be nd Mental marked o matic eva	2	MORRIS E. KERN								ABETH 1				
<u>lar</u>	2 should and Mark		19a. Informant's Name/Relationship (				•					City or Town, St			
	as 1 and 2 should to of Health and Ment I Item 27 is marked rother traumatic		SHARON R. LEVINE/ 20a. Method of Disposition	DAUGHIER	20b. PI	14/1/ ace of Dispo emetery, crer				ET, G		SBURG . M 0c. Location - Ci		LAND 208	<u>/8</u>
و	Pages nnt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Dopation 5 ☐ Other (Specific		9				UAI	N 18,	25-02		zenomo:		202
altimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral 3. rvice Licel		IKING	G DAVI				004	F/	ION, INC	RCH.	VIRGIN	A
ñ	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		IMALLETT			ED 10	WARD 91 RO	SAGE OCKVI	L FUN] LLE P	ERAL IKE.	DIRECT] ROCKVII	ION, INC LLE, MAR	· YI.Al	ND 2085	2.
			23a. Part1 Enter the disease, or com- sheck, or heart failure. List only	plications that caus one cause on each	ed the death			-						Approximate Interval Between	
	Physician		Imprediate Cause (Final disease or condition	a LUNG C										Onset and Death MONTHS	
	/Medical Examiner		resulting in death)		is a consequ	ience of):									
	Lammer	<u>.</u>	Sequentially list conditions,	b Dula to the a	ie a consequ	anea offic									
	rted Insit	Examiner	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury	,		one ery.									
,	execu in and ial-tra		that initiated events resulting in death) Last	Due to (or a	is a consequ	ence of):									
8760	cate be executed physician and the burial-transit	dicai		d											
<b>39</b> )	artifica ing ph e as th	Med	IF FEMALE:											(Action)	-
Вох	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3[	Ectopic p					23d. Date of Month		y Day Year	
O	it the de by the a tached f	ysic	1 ☐ Yes 2X No 9 ☐ Unknown	4∏Pregnant 9☐ Unknown	at time of de	atn 5∟	J Other (s)	оөспу)							
۳.	es that tigned by	y Ph	Part II. Other significant conditions of	ontributing to death	but not resu	iting in the u	nderlying (	ause give	n in Part I.		23e. Did toba	cco use contribu	te to the	cause of death?	
rds	quires n sign	d by								_	1 🔀 Yes	2 □ No 3 [	] Proba	bly 4 □Unkno	wn
Ö	sw require s been si	plete									24a. Was an	24b. We	e autop	sy findings availa pletion of cause of	ble
Vital Records,	sicien: The law certificate has t irector, page 2 s	Completed									autopsy performe	ed? dea			"
ıta	ilcien: Th certificate rector, paq	Be C	25. Was case referred to medical examiner?					1		f Death (C	heck only one				_
> >	Physic this ce al dire	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa		ER/Outpatien			4 🗀 Nuis	-		ce 6 □Other	Specify,		
Division of	ding P h. After i funera	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, D	Jury Jay Year)	28b. Time of Injury	м	28c. Injury Work	at ? ′es 2 ∐ No		. Describe now	injury occurred			
S	tan Jeat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be		njury - At hoi	me, farm, str			00 2			et and Number o	r Rural	Route Number,	
2	after after Dire	erti	4 Homicide determined	28e. Place of I building,	etc. (Specify	)					City or Town,	State)			
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Pt	nysician: To the bes niner: On the basis	st of my know	vledge, death	occurred	at the time	e, date and	place, and	due to the cau	se(s) and manne	er as sta	ted.	
	the Ho in 24 the Fu ipletel	ledical	one)	and manner						occurred a					
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	+				c. License		0-11		d. Date signed (A		•	
4.	10		Mund	(a)	i al-auto (IX-	000) /T =						1-17-0			
			30. Name and address of person who	C 1X11	. 0	23a) (Type,	Phili	o De	N2 =#	328	Olue	1.MD	20	832.	
	Sta	te	31. Date filed (Month, Pay, Year) JAN 22 20	32. Regis	trar's Signat	<u> </u>		The second	j <u>e i 177</u> j	1-0	0 1/01	1 · · · · · · · · · · · · · · · · · · ·			
	Registr		JAN ZZ ZU	U4 /5	wes	P	MOC	W. F.L.							

			Tor State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylan		artment of I rtificate of			g. No. 2004	03 {	884
	Physici	an			T ANTZ	ADOME		Month	Day Year		
5	/Media		MARILYI 4a. Facility Name (If not institution, give s		LANZ	ARONE 4b. City, Town, o	or Location of D	JAN.	21, 2004 4c. County of Death	2:40	<b>P</b> M
	Examir	ier	MONTGOMERY VILI		TOME		GOMERY '			DV	
	Funeral	_	5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 l	rs. 8. Date of Birth	MONTGOME 9. Birthp	lace (State o	or Foreian
	Director		473-28-9129 Usual Residence of Decedent	<sup>™ 2</sup> <b>X</b> F 74	Yrs.	Months Days	Hours	AUG. 4,	1929 MIN	NESOTA	<u> </u>
	ylan how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				0d. Inside C	ity Limits
	B-f	ctor	MD. MONTGOMI	ERY		MONTGOMEI	RY VILL	AGE		1 XYes	2 🗌 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?	
	23e	le le	19301 WATKINS	MILL RD.		20	0886		U.S.A.		
	tems	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	tispanic Origin? an, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White,		
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes <b>2</b> No If Yes, Give		1 ☐ Yes 2 🛣 No			Specify:		
2-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow ha Modical Examiner must be notified at	p p	15. Decedent's Educ	Year or Dates:	160 Door	dont's House Ossur	tion		WH	ITE	
ή	n 72	Completed	(Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Business/In	dustry	
2121	withi ene. then	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		HOUSEWII	•		HOME		
0	Hygi Hygi other		17. Father's Name (First, Middle, Last)			HOUDDWIN		Name (First, Middle, N			
au	id be ental ked o	To Be	WILLIAM	WINTHEISE	₹			ALICE	BORNGESS	FR	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 Ie marked other then "netural", or Items 23e or 28e-f ehow other traumatic event, the Mcdical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type			ng Address (Street			City or Town, State, Zig		
	and 2 salth a n 27 le		VICTORIA DOWDY	DAUGHTER					VN, MD. 208		
altimore,	permil. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.		20a. Method of Disposition	20b. P		sition (Name of matory or other place			Oc. Location - City or To		
Ë	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ Ri 1 ☐ Donation 5 ☐ Other (Specify)	emoval mom state		CREMATOR		23-2004	RIVERDALE,	MD	
	mil. I		21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility				
m	Depar Impor eny ir		1/1/1/1/ha	mberson mood	U.	HWRRFK2 1	UNLKAL	HOME & CRI	MATORIUM,P DALE, MD. 20	.A.	
<b>)</b>	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as e consequ	Jence of):			Size or respiratory arre		Approximate Interval Bett Onset and I	ween
68760,	certificate be executed ding physician and use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
.O. Box (	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of delive Month	•	/ear
<u>a</u>	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions con	tributing to death but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to the	e cause of d	eath?
g	luires n sign	d by						1 ☐ Yes	s 2⊅No 3□Prob	ably 4 □U	Inknown
ecords,	w require been sig should b	leted						24a. Was an	24b. Were auto	ney findings	available
Re	9 2 9	Compl						- autopsy perform	prior to con	npletion of ca	ause of
Vital	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					1 Yes 2		2 No	
	ysician: is certific director,	o B	examiner?	ospital:	ER/Outpatier	at 3 DOA Oth		Death (Check only one	nce 6 Other (Specify		
ō	ig Phy ter this neral c	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe hov		")	
0	nding I tth. :: After e funer	atio	1 Accident 5 Pending investigation	(Month, Day rear)	Injury		k? Yes 2 □ No				
Division	ne Hospital or Attending Physician: 7.24 hours after death. Ne Funeral Director: After this certific details in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	gu	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Numi	ber,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemin	icien: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the cat ocurred at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)	)
	To t To t	Σ	29b. Signature and title of centrier	1101		29c. Licens	e number	29	d. Date signed (Month, I	Day, Year)	
)			) JALL	July 1		No	05128	3	1-22-20	Pool	
	,		30. Name and address of person who cor	mpleted cause of death (Item	23а) (Туре,	<del></del>		-		•	
			ANUSHIRAVAN DA	DGAR, D.O.,	9715 1	MEDICAL C	ENTER D	R., #201,	ROCKVILLE,	MD.208	850
ľ	Sta Registr		31. Date filed (Month Day Year) JAN 23 200	32. Registrar's Signat	ure &	Sparks	/				

RKD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

292		Please 7	Type or Prin	t in Bla	ck In	delible Ink.	Ensure A	All Copies	Are	Legible.	
		For State	State of Ma	ryland /	-			Mental Hy	gien	e2004	03885
		1 - State Registrar			Cei	tificate of	Deam	2. Date of D	Reg. N	0.	3. Time of Death
Physicia	an	1. Decedent's Name (First, Middle, Last						Month	Da	y Year	
/Medic	al	Lillian A. La				4b. City, Town, o	Location of Doo	JANUAI	1	11,2004 c. County of Death	1:25P. M
Examin	er	4a. Fecility Name (If not institution, give				BETHES!		W1		ONTGOMER	
		5407 CHRISTIE DRINGS. Social Security Number 6. Se		(In yrs. last l	hirthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bi	1		place (State or Foreign
Funeral Director		064-12-8632	THE OFFICE	86	Yrs.	Months Days	Hours Mir		ay, Ye <i>ai</i>	17 New	York
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
vlanyi f ehc	0	Maryland Montgom	ery		Beti	hesda					1 ☐ Yes 2 No
28a	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
With With	0	5407 Christy Dr.				208	16			U.S.A.	
heath	Funeral	11. Marital Status	12, Was Decedent B	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (	Specify Yes or N	0-	14. Race - Amer	
riter (	Ē	1 XNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N	lo				no Hican, etc.)		Black, White	
urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:			Specify: Wh	ite
2 ho	ted	15. Decedent's Edu (Specify only highest grad	ucation	16	6a. Dece	dent's Usual Occup	ation	orking	16b. I	Kind of Business/la	ndustry
thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retired	1)	,g	77	·	
gien gien	Con		4		Div	ision Chi				oice of A	merica
al Hy	Be (	17. Father's Name (First, Middle, Last)						ıme <i>(First, Middl</i> e armela C			
Meni Meni mrke atic	2	Alex LaMacchi									
and and is m		19a. Informant's Name/Relationship (T)				ng Address (Street anford Ro					
and ealth m 27		Neil Costello/ N	lepnew			allI Of a Ro	1., NOIL	Date		ocation - City or T	
Fite F		20a. Method of Disposition 1 Burial 2 Cremation 3 6	Removal from State	ceme	tery, crer	natory or other place				•	
Tant:		* 4 □ Donation 5 □ Other (Specify,		Mt. C		rt Crema					, Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "neturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar Interior excition any once.		21. Signature of Funeral Service Licens	Xareh	MO12	96 5	Name and Addre	<sup>ss of Facility</sup> Jo onsin Av	oseph Ga ve., NW,	wler Was	's Sons, hington,	Inc. DC 20016
*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. D	o not ent	er the mode of dyin	ig, such as cardia	ac or respiratory	arrest,	disease	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Hypotherm		plice	rting hypor	tensive ath	prosdoratic c	<i>lardic</i>	ovascular	Onset and Death
/Medical		resulting in death)	Due to (or as			0 1					
Examiner		Convention by liet conditions	b								
n =	ner	if any, leading to immediate	Due to (or as	a consequenc	ce of):						
executed in and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
an ar	Ex	resulting in death) Last	Due to (or as	a consequenc	ce of):						
ate be nysici		(	d								
The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE:									
th ce tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1⊟Live birth			Ectopic pregnancy	,		9	23d. Date of deliver Month	rery Day Year
e dea	sici	in the past 12 months? 1 □ Yes 2 ▼ No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 [	Other (specify)				WOM	buy rou.
at the de	Phy	9 Unknown		at and an existing	a in the	- dash isa anung au	on in Oast I	220 Did	tobacco	uco contabuta to	the cause of death?
w requires that been signed b should be deta	by	Part II. Dther significant conditions co		ut not resultini	g in the u	ngeriying cause giv	en in Part I.				bably 4 Unknown
pluoi s nee	ted	Extremity In	w, (2)					-	105	2 M/ 140 3 11 10	
law as be	Completed							24a. Wa auto	psy	prior to co	opsy findings available ompletion of cause of
The law	Con							1 X Yes	ormed? 2 ☐ N	o death?	2□ No
Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						eath (Check only	опе)		
Physic this ce ral dire	Lo	1 No 2 No	Hospital: 1   Inpatie		Outpatier		4   Nursing			6XOther (Special	//SCENE
gr en	Certification:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	Year) 28t	b. Time of	Wor		28d. Describe			to cold
eath. or: A	catl	2 Accident investigation	1 cames 1 112		1:00		Yes 2 No	3		and fell	
al or Attending s after death. I Director: After d in by the fune	Ę	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, c. <i>(Specify)</i>	farm, str	reet, factory, office		City or To	wn. Sta	and Number or Rui	mistiz Driva
oital ( urs af ral D						•		13eH	uesd.	a mo	
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	(Check only 27 Medical Exem	/sicien: To the best of iner: On the basis of	examination	dge, deat and/or in	h occurred at the tire vestigation, in my o	ne, date and place pinion, death occ	se, and due to the curred at the time	cause( , date a	s) and manner as: nd place, and due:	stated. to the cause(s)
the thin 2 the mplet	Med	29b. Signature and title of certifier	and manner sta	IIO.		29c. Licens				ate signed (Month	
17		A A S	m.D				M.E.			UARY 12.	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINGLI, M.D.

31. Date filed (Month, Day, Year)

JAN 2 0 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			1 - Stete Registrar	State of Maryland / Dep Ce	ertificate of De	ilth and M ath	ental Hygie	ene 2004	03886
i	Physicia		1. Decedent's Name (First, Middle, Last) Armando	S.	Lagman		2. Date of Death Month JANUARY	Day Year 17, 2004	3. Time of Death 7:55A. M
,	/Medic Examin		4a. Facility Name (If not institution, give st CIVISTA MEDICAL CEN		4b. City, Town, or Local La Plata	ation of Death		4c. County of Deat	h
	Funeral Director		377-70-3700	7. Age (In yrs. last birthday 63 Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth Month, Day 03/12/19	(aar) Co	hplace (State or Foreign untry) lippines
	Maryland -f show lited at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Charles	s Waldor					10d. Inside City Limits 1 ☐ Yes ※XXNo
	with the 3a or 28e	i Director	10e. Street and Number 5115 Vest Lane		10f. Zip Code 2060	01	100	g. Citizen of What Co USA	untry?
2	be filed within 72 hours after death with the Maryland Hydjone. At Hydjone. Ad other than "natural", or items 23s or 28s-f show event, it a Medical Exacilizer must be notified at	by Funerai	11. Marital Status 1.  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1  Yes XX No If Yes, Give Year or Dates:	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes ※ No Sp	nic Origin? (Spe lexican, Puerto l pecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Fil	e, etc.
0-0171	within 72 hor lene. than "nature it a Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)  16a. Decc (Given life.)	edent's Usual Occupation e kind of work done during DO NOT use retired) Bus Boy	n g most of workii		bb. Kind of Business/ estaurant	
ומווא	e d la b	To Be C	17. Father's Name (First, Middle, Last) Federico Lagman		18.		(First, Middle, Ma	iden Sumame)	
Maiy	s 1 and 2 should f Health and Mer Item 27 le marke other treumatic		19a. Informant's Name/Relationship (Type Susana Tan Lagman		ing Address (Street and N				
11016,	permit. Peges 1 and 2 Department of Health Importent: if Item 27 I any injury or other tro		20a. Method of Disposition  1XOBurial 2 ☐ Cremation 3 ☐ Re  14 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre		0	ate 20	C. Location - City or Clinton, M	Town, State
Dall	permit. I Departm Importer any inju		21. Signature of Luneral Service Licenses	la h	22. Name and Address of Geo 6160 Uxon Hi	orge P.	Kalas Fu	neral Hom	e P.A.
	hysician		23a Part1 Ther the disease, a complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	rations that coused the death. Do not er a caus on each line.  Hypertoniciva othersis	nter the mode of dying, su	uch as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
1 . Ok	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
,00,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):					
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rai director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
L (22)	quires that n signed build be deta	ρχ	Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given in	Part I.		cco use contribute to	/
חספת ונ	sician: The law require s certificate has been sig lirector, page 2 should b	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
01 A 16	hysician his certifi il director	To Be	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ospital: 1 ☐ Inpatient 2X ER/Outpatie	ent 3 DOA Other: 4	Nursing Hor		ce 6 ⊡Other (Spec	city)
	ogu eur	Certification:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Surcide 6 ☐ Could not be	28a. Date of Injury 28b. Time (Month, Day Year) Injury	Work? M 1 ☐ Yes	2 🗆 No	28d. Describe how		
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: Atter this certificate h completely filled in by the funeral director, page		4 Homicide determined	28e. Place of Injury · At home, farm, s building, etc. (Specify)			City or Town,		
	the Hosp in 24 hor the Fune ipletely fi	<b>l</b> edical	(Check only 2 Medical Examination one)	ician: To the best of my knowledge, dea er: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion	n, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To with	Σ	29b. Signature and title of certifier	~ ( ``>	O.C.M			Date signed (Montl)	
/	(3)		30. Name and address of person who con		, Print) 111 Penn St	reet, B			
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 1 2004	2. Registrar's Signature	alls)				

		•	For State Registrar	State of Maryla	ind / Depa		ealth and	Mental Hyg	_	03887
	Physicia /Medic		Decedent's Name (First, Middle, Last)     CLIN SUP LEE.					2. Date of Dea Month	Day Year 10, 200	4 8:30 P M
	Examin Funeral Director		4a. Facility Name (If not institution, give s 3347 HEWITT AVE. 5. Social Security Number 214-19-9903	APT. #201	s. last birthday) Yrs.	SILVER If Under 1 Year Months Days		s. 8. Date of Birth		
Maryland d 2 should be file	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Mucical Examinar must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD MONTGOMET  10e. Street and Number  3347 HEWITT AVE. A	APT . #201  12. Was Decedent Ever in Armed Forces? 1   Yes 201  14. Yes, Give Year or Dates: cation e completed)  College (1-4or 5+)  4. Approximately College (1-4or 5+)  App. Print)  Removal from State	16a. Dece (Give life. SECU 19b. Mailii 3347	RING  10f. Zip Code  20906  Was Decedent of H If Yes, specify Cuba  1 Yes 2 XNo  dent's Usual Occupp, kind of work done of DO NOT use retired  RITY AGEN  and Address (Street at  HEWITT AV  sistion (Name of matory or other place	Specity:  ation furing most of we  T  18. Mother's Na  BYOUN and Number or F  E. APT.;	Specify Yes or Nortic Rican, etc.)  orking  ame (First, Middle, G SU O  Rural Route Numbe # 201 SILV Date	USA  14. Race - An Black, Wr Specify: AS  16b. Kind of Busines	10d. Inside City Limits 1  Yes 2 No Country?  Tenerican Indian, ite, etc.  SIAN  s/Industry  SECURITY  Zip Code)  M1 20906  Town, State
760, te be executed XI > 7	sician and Medical aminer	ical Examiner	if any, leading to immediate cause. Enter Underlying	ications that caused the de ne cause on each line.	r of th equence of):		g, such as cardi			Approximate Interval Between Onset and Death From 2002
ords, P.O. Box 68 requires that the death certifical	ed by the attending phy detached for use as the	Physician/Med	in the past 12 months?  1 Pes 2 No 9 Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etel death 3[ f death 5[	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	Day Year
<b>Vital Records, F</b> sici <b>a</b> n: The law requires tha	has been sign ge 2 should be	Completed by F	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	inderlying cause give	en in Part I.	1 ☐ Y 24a. Was a autop perfor	an 24b. Were a prior to death?	to the cause of death?  Probably 4 □Unknown  autopsy findings available be completion of cause of
ivision of or Attending Phys	death. tor: After this certific the funeral director.	Certification; To Be Co	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	Hospital:  1	28b. Time of Injury	f 28c. Injun Worl M 1	er: 4 🗆 Nursing	28d. Describe h	ence 6 Other (Spow injury occurred	ecify)
Hospita	4 hours Funeral tely filled	edicai	(Check only 2 Medical Exami	sician: To the best of my k ner: On the basis of exam and manner stated.		vestigation, in my o	pinion, death occ	curred at the time, o	date and place, and do	ue to the cause(s)
) i	within 2  To the complete	Σ	30. Name and address of person who co				033		29d. Date signed <i>(Moi</i>	
	Sta Regista		Dr.B.K.Lee 13000 31. Date filed (Month, Day, Year) 14 2004	22. Registrar's Sig	gnature		s, Ma.20	7700		

			1 - For State Registrar	State of	Marylan		artmen rtificate			nd M		eg. No.	200	Ļ	03	888
	Physici	an	Decedent's Name (First, Middle, La	st)							Date of Dea     Month	th Day	Ye	ar	3. Time o	f Death
	/Medic		BEULAH	LEGGETT			45 000	T	t continu	Dooth	1 1		2004 County of D	Saub	4:05	_ A M
	Examin	er	4a. Fecility Name (If not institution, give		er)				Location of SPRI			46. (			MERY	
	Funeral		HOLY CROSS HOSP I  5. Social Security Number 6.5	Sex 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	4 Hrs.	8. Date of Birth (Month, Day	Voar				or Foreign
	Director		237-60-7462	1□M 2\\ F	62	Yrs.	Months	Days	Hours	Min.	5 28	194	+1 N	ORTI	ace (State try) H CAR(	OLINA
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside C	ity Limits
	Maryla f sho	5		GEORGE'S			ANDOV	ΤD								2 🗆 No
	r 28a	rect	10e. Street and Number	GLORGE 5			10f. Zip				1	0g. Citiz	en of Wha	t Coun	try?	
	th with	al D	7531 ALLENDALE	DRIVE				2078	5				U.S.	Α.		
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at anone.	by Funeral Director	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Forc 1  Yes 2 If Yes, Give Year or Date	es? (a) No	'	Was Deced f Yes, spec 1  Yes	rify Cuba	n, Mexican,	in? (Spo	ecify Yes or No- Rican, etc.)		4. Race - A Black, V Specify:	Vhite, e		
8	2 hou		15. Decedent's E	ducation		16a. Deced	dent's Usua	I Occupa	ation			16b. Kin	d of Busin	ess/Ind	lustry	
21215-0036	thin 73	ple	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4	or 5+)	(Give	kind of wor DO NOT us	rk done a se retired,	luring most )	of work	ing					
	ygien ygien yer thu	Completed		2+		FOOD	SERVI	CE					PRIVA	TE_		
and	be fill Had Had off	Be	17. Father's Name (First, Middle, Last								(First, Middle, I					
Maryland	hould d Mer marks martic	2	LESLIE N 19a, Informant's Name/Relationship (	ICLEAN		19b Mailir	ng Address		Annie		ell McC	Calis Civor		te Zio	Code)	
<u>⊠</u>	od 2 s lith an 27 is traus		CHARLES LEGGETT		BAND	1	-				ANDOVER				0785	
	s 1 ar f Hea itam other		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. P	lace of Dispo emetery, crer	sition (Nan	ne of	T				ation - City	or To	wn, State	
Ë	Page nent o nt: If iry or		1 ☐¥Surial 2 ☐ Cremation 3 ☐  1 ☐Donation 5 ☐ Other (Speci		ate	LINCOL				-24-	2004	BREI	יחסעדע	D . I	MARYL	AND
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	shall			. Name an	d Addres	s of Facility	J	.B. JENK D LANDOV	CINS	FUNE	RAL	HOME	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the deatl th line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	or respiratory arr	est,			Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	a G I	BLEED	ING									Onset and	Death
1/2	/Medical Examiner		resulting in death)		as a conseq											
		_	Sequentially list conditions if any, leading to immediate		TE MYC	CARDIA	L INI	'ARC'	TION					-		
	nsit	Examiner	Cause (Disease or injury	CAE	DIAC A											
Ć	te be executed ysicien and te burial-transit	Еха	that initiated events resulting in death) Last	C.	as a conseq											
8760,	ate be executed hysicien and the burial-transit	cal		_ d										J.		
9	ng ph	ed .	IF FEMALE:				· · · · · · · · · · · · · · · · · · ·									
.O. Box	uires that the death certifics is signed by the attending ph Id be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		h 2∐Feta ntattime ofd	Ideath 3□	Ectopic pro Other (sp					2	3d. Date of Month		-	Year
Ω.	The law requires that the ste has been signed by th bage 2 should be detache	by Ph	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	bacco us	e contribu	te to th	e cause of	death?
rds	w require: been sig should b										1 🗆 Ye	es 2□	]No 3[	] Proba	ably 4 🔀	Unknown
Records,	aw re	Completed									24a. Was a		24b. Wer	autop	sy findings	available
m		ĕ									perforr		deat	h?	X No	A4430 01
Vital	ician: Th certiticate rector, pag	Be (	25. Was case referred to medical examiner?					1.		of Death	(Check only on	(0)				
of	ding Physician: h. Atter this certifical	ဥ	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatien			4   IAUI	-	me 5 Reside			Specify	)	
uc	fing Atter	lo	1 XNatural 5 ☐ Pending	28a. Date of (Month,	Day Year)	Injury	M	8c. Injury Work	at {? /es 2. □ N		28d. Describe ho	ow injury	occurred			
Division	I or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, str y)	-		.03 2		28f. Location (St City or Town	treet and n, State)	Number o	r Rural	Route Nun	nber,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely tilled in by the	edlcal C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examina	wiedge, death tion and/or in	occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, h occurr	and due to the caed at the time, d	ause(s) a ate and	and manne place, and	r as sta due to	ated. the cause(	s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier					License					signed (M			
)			<b>)</b> (6	har	n	D	لي ا	Don	5606	- 3		JA	1 20	12	2004	
2	(5)		30. Name and address of person who KANWALJIT K.				Print)				SPRING	, MA	RYLAN	D 2	0910	
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 3 2004		gistrar's Signa	ture.	٠,									

**ORIGINAL** 

		Registrar  1. Decedent's Name (First, Middle	Lasti		00	rtificate of	Dodin	2. Date of De	Reg. No.	E 0 0 1	3. Time of	Death
Physicia	n	Barbara Jean						Month 01	Day 14	Veer 04	1:12	РМ
/Medica Examine		4a. Facility Name (If not institution		nber)		4b. City, Town,	or Location of Dea		-	County of Deeth		
LAdillille		Surburan Hospi	tal			Bethes	sda		Mo	ntgomery	7	
ał		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year   Months   Days			rth ay, Year)	9. Birtho	place (State of	r Foreign
or		578-56-7728	1□M 2द्रF	60	Yrs.			11 2			ington,	
1	}	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or L	ocation					10d. Inside Cit	ty Limits
	5	MD Montgo	merv		ethesda						1 <sub>₹</sub> Yes	2 🗆 No
	Director	10e. Street and Number	mery			10f. Zip Code			10g. Citi	zen of What Cour	ntry?	
6		4521 East West	Highway	#101		208	314			USA		
	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cul		Specify Yes or N	0-	14. Race - Americ Black, White,		
		1 ☐ Never Married 2 ☐ Marri				1 Tes 2 TNo		ito i noati, oto.,		Specify: Bla		
	d b	3 Widowed 4 Divorced	Year or Di	ates:								
1	ete	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	ident's Usual Occu is kind of work done DO NOT use retin	ipation oduring most of w	orking		nd of Business/In	-	ies
	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		rty Manag				ission N		
		12 17. Father's Name (First, Middle, I	Last)				18. Mother's Na	ame (First, Middle				
•	To Be	George D. Lewi	s, Sr.				Mattie	A. Edge	9			
1		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ing Address (Stree	t and Number or F	Rural Route Numb	er, City o	r Town, State, Zip	Code)	
		Joseph C. Linds	ey So			North Sh		re #22 Re	eston	, VA. 20	)190	
1		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	2 - Removal from	20b.	Place of Disponentery, cre	osition (Name of matory or other pla	ace)	Date	20c. Lo	cation - City or To	own, State	
		'4 □Donation 5 □Other (S)		Han	_	Memorial				over, MD		
Once.		21. Signature of Funeral Service I	Licensee			2. Name and Addr						
a		23a. Part1 Enter the disease, or shook, or heart failure. List	shall			217 9th.				D.C. 20	Approximate	
ing en	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to ( Card:  b. Due to (	ic Encoror as a consector as a conse	quence of): est	pathy					Onset and E	Joann
	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 \overline{\text{ZNO}} \ 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   The past 12 months?								23d. Date of delive Month	*	/ear
detached	Y P	Part II. Other significant condition	ns contributing to de	eath but not re	sulting in the u	underlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute to the	he cause of de	eath?
								10	Yes 2[	□No 3 □ Prob	ably 4 □U	Jnknown
ge 2 should be det	piet							24a. Was		24b. Were auto	psy findings a	available
	Completed							auto perf	ormed?	death?		4030 UI
ſ	Φ.	25. Was case referred to medical					26. Place of De	eath (Check only				
	ToB	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1反1	npatient 2	] ER/Outpatie	nt 3 DOA	ther: 4 🗆 Nursing	Home 5 ☐ Res	idence 6	6 □Other (Specif	y)	1 200
		27. Manner of Death 1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	jation	of Injury th, Day Year)	28b. Time o Injury	We	ury at ork? ] Yes 2 □ No	28d. Describe	how injury	y occurred		
	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 209. Place	of Injury - At h	nome, farm, st ify)	reet, factory, office			Street and wn, State,	d Number or Rura )	il Route Numi	ber,
	Medical		g Physician: To the Examiner: On the ba and man									)
completely filled	Ž	29b. Signature and title of certifier	)			29c. Licen	se number			e signed (Month,	-	
		grunn	/	Sin	,	D378	91		Janua	ary 14,	2004	

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JAN. 12, **Physician** 2004 1945 JOANIE MAE MYRICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville MONTGOMERY 8. Date of Birth (Month, Day, Year) Mar. 30, 1946 7. Age (In yrs. last birthday). If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □X Months Davs Hours 215-44-3689 Wash. Director DC Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD 1√Yes 2□No Montgomery Director Derwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7229 Mill Run Drive 20855 U.S.A. death Funeral Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 'naturai', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other then. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Hall Fannie Mae Tuell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Myrick (Husband) 7229 Mill Run Dr., Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or conce. Arlington Nat'l Cem 1/29/04 Ft. Myer, VA 2) Signature of Funeral Service Lice view 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute Arrythmia Physician Minutes resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Diceas of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 28 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by pe 1 Yes 2 No 3 Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Yes 2 □ No 2 ER/Outpatient 3□ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1X Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the cause(s) and manner as stated. 29a. Certifier Medica (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51980 Jan. 12, 2004 30. Name and address of person who complet id cause of death (Item 23a) (Type, Print) Brett Gamma, M.D. 9901 Medical Center Dr., Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 20** Registrar

			For State Registrar	State of	Marylan	-	rtment <i>tificate</i>			and M		Reg. No.	71101.	03891
	Physicia		1. Decedent's Name (First, Middle, Last Ruth Ellen Bel								2. Date of De. Month Januar		, 2004	3. Time of Death 2:12 A M
	/Medio Examin		4a. Facility Name (If not institution, give Heartland Health						Location o	of Death		4c.	County of Deat	orge's
I	Funeral Director		311 00 3010	х ]м 2∏F	7. Age (In yrs. 82	last birthday) Yrs.	If Under	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da March	v. Year)	9. Birt 921 Was	hplace (State or Foreign unity) hington, DC
	e Maryland 3e-f show	Director	Usual Residence of Decedent  10a. State  10b. County  N/A			y, Town or Lo	on							10d. Inside City Limits  1X Yes 2 No
	3a or 24	al Dire	10e. Street and Number 5125 Chillum Pla	ice, N.I	Ξ.		10f. Zip	Code 0011					en of What Co ted Sta	•
980	d within 72 hours after death with the Maryland Jiene. r than "neturel", or items 23a or 28e-f show the Medical Examinet meat be multified at	by Funeral	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	12. Was Dece Armed For 1  Yes If Yes, Giv Year or Da	2 <b>X</b> No 9		Was Decede f Yes, speci		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: B	
21215-0036		Completed	15. Decedent's Ed (Specify only highest grad	cation le completed) College (1	-4or 5+)	16a. Deced (Give life. I	lent's Usual kind of word DO NOT use istra	k done d e retired)	uring most				nd of Business/	Industry Vernment
Maryland 2	al Hyg	To Be Co	17. Father's Name (First, Middle, Last) unavailable						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
a r	es 1 and 2 should b of Health and Ment: I Item 27 is marked r other treumetic		19a. Informant's Name/Relationship (7) Randolph Muse (h 20a. Method of Disposition	ype, Print) usband)			Chil.	lum	P1. N	Ν.Ε.,	al Route Numbe , Washii Date	ngto		20011
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any Injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licenses)		state !	ryland 22	Nati . Name and	onal Addres	s of Facilit		ire Fu	nera.		ce
Ä	Per Control		23a. Part1. Enter the disease, or compshock, or heart failure. List only of	lications that can	aused the death								ington,	D.C. 20012 Approximate Interval Between
68760,	rate be executed Wedician and hysician and the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Early in deplying Cause (Disease or injury that intitated events resulting in death) Last	Due to (	ceriosc or as a consequ or as a consequ or as a consequ	uence of): uence of):	c Car	diov	ascul	lar I	isease			Onset and Death years
.O. Box	at the death certifical by the attending phy itached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		irth 2 □ Fetal ant at time of d	Ideath 3	Ectopic pre Other <i>(spe</i>					2	3d. Date of deli Month	ivery Day Year
rds, P	quires that n signed b	Ď	Part II. Other significant conditions on Dementia	intributing to de	ath but not resi	ulting in the u	nderlying ca	iuse give	n in Part I.			_		the cause of death?
of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	Stage IV Sacral	decubi	tus								prior to death?	topsy findings available completion of cause of
Vita	sicien: certific rector,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	npatient 2	ER/Outpatien	t 3 🗆 DO	A Othe	_		n <i>(Check only o</i> me 5 □ Resid		□Other (Spec	
	Jing After fune	-	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation		of Injury h, Day Year)	28b. Time of Injury		Bc. Injury Work		2	28d. Describe h			,
Division	- e = -	Certification;	3 Suicide 6 Could not be 4 Homicide determined		of Injury - At hong, etc. (Specify		eet, factory,	office		2	28f. Location (5 City or Tox		I Number or Ru	ral Route Number,
	To the Hospitel of within 24 hours af To the Funerel D Completely filled in	Medical	29a. Certifier 1 A Certifying Phy (Check only 2 Medicel Examone)		isis of examina		estigation,	in my op	inion, dea		ed at the time,	date and	place, and due	to the cause(s)
,	With	2	29b. Signature and title of certifier	nle	In	e 40		License					signed (Montle lary 22	
			30. Name and address of person who of Paul A. DeVore, M.		e of death (Item 203 Que	-		1, H	yatts	vill	e, MD	2078	1	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 3 200	32.	egistrar's Signa		Spo							

		•	For State Registrar	State of Maryland	d / Depa	artmei <i>rtifica</i>	nt of H	ealth a Death	nd Me		iene2 ()	04	03892
	Physici		Decedent's Name (First, Middle, Last)     Anita Murray				-		1	2. Date of Death Month January	Day	Year	3. Time of Death
*	/Medio		4a. Fecility Name (If not institution, give s				Town, or	Location of		January	4c. County	of Death	3. Time of Death  8:30A  ath  10d. Inside City Limits  1
	Funeral Director		3618 Littledale Ro 5. Social Security Number 6. Sex 048-18-6869		ast birthday) Yrs.		r 1 Year	If Under 2	Min.	8. Date of Birth (Month, Day, Mar 21,	Year)	9. Birthp Cou/	place (State or Foreign htry)
	the Maryland 28a-f show notitied at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom  10e. Street and Number		, Town or Lo	ton	ip Code			10	Og. Citizen of		1 ☐ Yes 2 X No
980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funerai	3618 Littledale R  11. Marrial Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d, #205  12. Was Decedent Ever in U. Armed Forces?  1  Yes, Give Year or Dates:					in? (Spec Puerto R	cify Yes or No- lican, etc.)		ck, White,	etc.
215-0	ithin 72 ho le. han "naturi	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Dece (Give life.	kind of w DO NOT	ork done d use retired	during most	of workin	g	16b. Kind of B		·
Maryland 21215-0036	id be filed w lental Hygier ked other ti Ic event, In	To Be Col	17. Father's Name (First, Middle, Last)  George C. Murray	5+		Teac	her			(First, Middle, M		atior ne)	)
Mary	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Ty) Nancy Warmington/		1			and Number	r or Rural	Route Number, 6, Balt			
Baltimore,	Peges 1 ar		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	lace of Dispo emetery, crea	osition (Na matory or	ame of other plac	9)	Da		20c. Location	City or To	own, State
Balti	permit. Departm Imports sny Inju		21. Signature of Funeral Service License	Somell	111	1800	New I	lampsh	ire		lver S		
	Physician		23a. Part1. Enter the diseast or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ı	Pneur			g, such as c	cardiac or	respiratory arre	est,		Interval Between
	/Medical Examiner	-		Due to (or as a consequence).  Due to (or as a consequence)	Post	Нера	tic				·		
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	Chroruence of):								
P.O. Box 68	that the death certifica ted by the attending pt detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	I death 3[	⊒Ectopic ⊒ Other (s	pregnancy specify)					te of delive	
Ś	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cor Macular degenerat	-	-		_						he cause of death?
Vital Record	The law reate has been	Completed	Blindness Osteoporosis							24a. Was ar autopsy perform 1 Yes 2	y led?	prior to co death?	ppsy findings available impletion of cause of 2 No
of Vita	ding Physician: The lav h. After this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner?  1 Yes 2X No	lospital: 1   Inpatient 2				er: 4 🗆 Nur	sing Hor	(Check only one	nce 6 Oth		(y)
<b>Division</b> c	Attending P	Certification;	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o	М		yat k? Yes 2 □ N	10	8d. Describe ho			I Courte Alember
Divi	To the Hospitel or Attenwithin 24 hours after deall to the Funerel Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify string)	v)			ne, date and		City or Town	, State)		al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in I	Medical		ner: On the basis of examina and manner stated.	tion and/or in	rvestigatio	on, in my o	pinion, death	h occurre	d at the time, da	ite and place,	and due t	o the cause(s)
)	10		30. Name and address the erson who od	mpleted cause of death (Item	23a) (Typa	Print)	D	536	91	7	する	7 h.	Day, Year) 16. 2004 20817.
	Sta	ate	ASAY KENNY 31. Date filed (Month, Day, Year)	, 63 20 [ 32. Registrar's Signa	De M	cre	y 1	Slud,	15	, eltrest	e, A	N) •	2811,
	Regist		JAN 23 20	14 Depens	2	100	rack	1					

State of Maryland / Department of Health and Mental Hygiene 2004 03893 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** William P. Mullin January 16, 2004 2:00 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Casey House Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Si (Month, Day, Year) | Virginia Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1\ M 2□ F 85 Yrs. Director 577-09-7416 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f ahow ral', or Itams 23a or 28a-f ahov Examiner trust be notified at 1 Yes 2 □ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 3919 Joliet St. 20906 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23 any injury or other traumatic avant, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S.
Apped Forces?
1 EYes 2 DNo 1942If Yes, Give
Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 257 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Grocery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mabel Warren 2 Francis Isaac Mullin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian G. Mullin- Wife 3919 Joliet St. Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Parklawn Mem. Park 01/19/2004 Rockville, MD ` 4 ☐ Donation \_5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary Fibrosis /Medical Due to (or as a consequence of): Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ Yas 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XXIo 24a. Was an autopsy performed? Yes 2⊟No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 When (Specify) Hospice Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number ertifier January 17, 2004 3 assumme স্থাৰিব cause of death (Item 23a) (Type, Print) M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 30 Named and address of person who come Loyson Karakunnel, 31. Date filed (Month, Day, Year)
JAN 2 0 2004 32. Registrar's Signature State

Registrar

souks

April an

			1 - For State Registrar	State of Ma	aryland		irtment of h		and Mental Hyg	iene 19. No. 2	004	03894
			1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		SARA RUTH	MODEL	L				JANUAR		2004	3:20P M
	Examin		4a. Fecility Name (If not institution, give st.	reet and number)			4b. City, Town, o	or Location o	of Death	4c. Cou	inty of Deeth	1
			HOLY CROSS REHAB				BURTONS				MONTG	
	Funeral		5. Social Security Number 6. Sex 1040-32-7712	7. Age M 2√2 F	e (In yrs. Ia 91	st birthday). Yrs.	Months Days		Min. (Month, Day,	Year)		plece (State or Foreign intry)
·	Director		Usuel Residence of Decedent		7.0				DEC. 14,	1912	NEW	YORK
	land ow		10a. State 10b. County	-	10c. City	, Town or Lo	cation					10d. Inside City Limits
:	Many Fitah	ţō	MARYLAND MONTGOME	RY	В	ETHEST	DΑ					1 TyYes 2 □ No
:	death with the Maryland ms 23s or 28s-f show r must be rediffed at	Directo	10e. Street and Number 4925 BATTERY LANE				10f. Zip Code	20814			of What Cou	of AMERICA
	7.7 hours after death with the Marylar "natural", or Items 23a or 28a-f show vilcal Exaction must be rediffed at	Funeral	11. Marital Status 11. Never Married 2 Married	2. Was Decedent I Armed Forces? 1 Yes 2 T		3. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Original Jan, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)		Race - Amer Black, White	
000	hours at tural', or al Exam	þ	3 ☐Widowed 4 ☐ Divorced  15. Decedent's Educi	Year or Dates:			☐ Yes 2☐ No  ent's Usual Occu				f Business/li	THITE
617	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Department of Health and Mental Hygiens in retural, or Items 23a or 28a-f ahov any injury or other traumatic event, If a Medical Examinar must be rectilied at once.	Completed	(Specify only highest grade		i+)	(Give life. L	kind of work done DO NOT use retire CEEPER	during most		MCCRO		PATMENT
5	Hygi other	Be Co	17. Father's Name (First, Middle, Last)			DOOR	CELLEIX	18. Mothe	r's Name (First, Middle, I	Maiden Sun	name)	
9	Aental rked c	To B	MORRIS FINGER					ANN	A MIRSKY			
al	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ			1			er or Rural Route Number			1/4
2	and and m 27 m 27 nor tr		ROBERT L. MODELL -	SON	OOL DI			ROAD,				JERSEY 08831
ore	Ser Fig.		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Re	moval from State	ce	metery, cren	sition (Name of natory or other pla				on - City or T	
aitimoi	Hant: Pag		'4 □Donation 5 □Other (Specify)		NATI		CREMATOR					I, VIRGINIA
g	Departing Departing Support Su		21. Signature of Funeral Service Licenses  Servalch C. X	tottle	mye	Z PAI	NZANSKY ( 70 ROCKV	GOLDBE ILLE P	y RG MEMORIAL IKE ROCKVIL	CHAPI LE, MI	EL IN 2085	IC.
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused a cause on each li	tha heath ne.	. Do not ente	er the mode of dy	ng, such as	cardiac or respiratory arr	est,		Approximate Interval Between Onset and Death
F	Physician			DEMENTIA								2 YEARS
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						
45		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Irijur)	Due to (or as	a consequ	ence of):						
	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury) that inflated events resulting in death) Last	2 - 1 - /								
8/00,	be exe ician a burial-		resolung in adding case	Due to (or as	a consequ	ence or):						
200	physicate physicate	dical	d.						-			
g XOX	leath certificate attending phys I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			le .			23d.	Date of deliv	very
-		Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnand Other <i>(specify)</i> _				Month	Day Year
ŗ.	that the led by the detache		Part II. Other significant conditions conf	tributing to death b	ut not resu	Iting in the ur	nderlying cause g	ven in Part I.	. 23e. Did tol	acco use o	contribute to	the cause of death?
	requires een sign hould be	d by	HYPERTENSION						1 🗆 Ye	s 2 🗆 N	o 3 ☐ Pro	bably 4 Nunknown
cords	w req	ete							24a. Was a		lb. Were aut	opsy findings available
ě	The law sate has b page 2 si	Completed							autops perforr	y ned?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of
Vital	eician: Th certificate irector, pag	0	25. Was case referred to medical					26. Place	of Death (Check only on			C 101110
		O B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 🗆 Inpatie	ent 2 🗆 l	ER/Outpatien	t 3 DOA	her: 4% Nu	rsing Home 5 Reside	nce 6 🗆	Other (Spec	ify)
סר	ig Phye ter this neral di	J. L	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju	y Year)	28b. Time of Injury	28c. Inju Wo	iry at	28d. Describe ho	w injury oc	curred	
<u>ö</u>	Attending F r death. ector: After by the funera	atle	2 Accident investigation				M 1	Yes 2 🔲				
Division	or Att after de Direct in by t	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town		ımber or Rui	ral Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical Co	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best er: On the basis o and manner st	f examinat	wledge, death ion and/or in	occurred at the trestigation, in my	me, date an opinion, dea	d place, and due to the cath occurred at the time, d	ause(s) and ate and pla	manner as	stated. to the cause(s)
	within 2 To the complet	Med	and Oil and Aller Africa				29c. Licen	se number	2	9d. Date siç	gned (Month	, Day, Year)
,	F ≯ F ŏ		296. Signature and title of certifier  AWathar	1 MI	$\rightarrow$		Doc	5361	15 I	chill	ceu. I	24, 2004
	2		30. Name and address of person who cor			23a) (Type				,	۱ (د	_ ,
			STATE OF THE PARTY	Mr. 111	75 b	CEUTT		SHITE	208, ROCKY	T.L.F	VII) 20	6.2
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signal	ture &	Spark	1	TOUR TOUR	a la factar y	1711 SU	

			1 - For AMEND#26perMD1 RegistraryMEND#14perINF	State of Ma 29/04 EMW 1/29/04, EM	arylan 1000 1,McCo	d / Depa <i>Ce</i>	artmen rtificat			ind M	lental H	ygiene Reg. No	C U U H	03895
			1. Decedent's Name (First, Middle, Last								2. Date of Month	Death Da	v Yea	3. Time of Death
	Physici /Medic		Yasmin K. Mitha								Janur		2004	10:10P. M
	Examin	er	4a. Fecility Name (If not institution, give 1406 Waterford Dr						Location of	f Death		i	. County of De	ath
			5. Social Security Number 6. Se		e /In vrs	ast birthday)		Air	If Under 2	24 Hrs.	8. Date of	Birth	arford	irthplace (State or Foreign
	Funeral Director		568-61-0598	M 2015	5'		Months	Days	Hours	Min.	(Month,	Day, Year) 3,195	_  _ (	country)
			Usual Residence of Decedent									,,,,,		
	nylan show	_	10a. State 10b. County			, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	8e-1-	Director	Maryland Harford		Bel	Air						T		
	within 72 hours after death with the Maryland iene. rthen "naturel", or Itame 23a or 28e-f ehow the Medical Examenational be notified at		10e. Street and Number 1406 Waterford Dri	₩.			10f. Zip	1015					izen of What ( ited St	·
	eath ne 234	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S 13			spanic Orig	in? (Spe	cify Yes or	1		nencan Indian.
<b>(</b> 0	r itan	T.	1 Never Married 2 Married	Armed Forces?			If Yes, spe	cify Cubar	n, Mexican,	Puerto	Rican, etc.)		Black, Wh	nite, etc.
93	rei', o	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	21XNo	Specify:				Specify:	ALCO-
2-0	72 h	etec	15. Decedent's Edu (Specify only highest grad			16a. Dece (Give	kind of wo	rk done d	urina most	of worki	ng	16b. K	ind of Busines	s/Industry
121	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5±)		oo noru ce Ma					Но	althcar	· · ·
d 2	be filed vital Hygie of other levent, It	e Co	17. Father's Name (First, Middle, Last)			0222	00 110			r's Name	(First, Midd			<u>e</u>
Maryland 21215-0036	9 7 5 5	To Be	Hasanali			San	i		Fatir	ma			Ramji	
ary	of Health and Ment of Health and Ment I Item 27 is marked r other traumatic	-	19a. Informant's Name/Relationship (T)			19b. Maili	ng Address	s (Street a	nd Number	r or Rura	I Route Nun	nber, City o	or Town, State	Zip Code)
	and 2	1 1	Kamrudin Mithani -	Husband					d Driv	ve B	el Air	, Mar	ryland	21015
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	C	lace of Dispo emetery, crei	matory or o	other place			ate	20c. Lo	ocation - City o	or Town, State
Ë	nit. Pages partment of lortant: If its injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)		Geo	orge Wa		-			/2004	Ade]	lphi, M	aryland
Baltimore,	permit. Page Department (Important: If eny injury or page)		21. Signature of Funeral Service Licens	ee .	1	Dx	าทลได้	V	s of Facility Borgwa	ardt.	Funer	al Ho	ome, P.	Α.
116	duzed		23a Pert 1 Enter the disease or comp	ications that caused	the death	14	400 D	as Druzo	~ Mill	PQ (	Pol+	CT 22 7 7	le, Mar	yland 20705
	4		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final					30 3. 3,	,,			4170011		Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as										1 week
ı	Examiner			Metast			carci	inoma	of u	nkno	wn pr	imary		5 months
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):								
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o										
90,	death certificate be executed e attending physician and id for use as the buriat-transit	E	resulting in dealth, Last	Due to (or as	a consequ	ience of):								
8760,	physics the b	edical		d										
Box 6	n certific anding p use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome									23d. Date of d	elivery
B	death e atter d for u	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic p ☐ Other <i>(sp</i>						Month	Day Year
0	the che	hys	9 Unknown	9∐ Unknown						-	_			
S, D	98 090	by P	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the u	nderlying o	ause give	n in Part J.				V	to the cause of death?
Records,	w requires been sign should be										11	Yes 2	<b>⊠</b> No 3□!	Probably 4 Dunknown
ecc	w as	Completed										topsy	prior to	autopsy findings available completion of cause of
= H	Th ate pag	S									1 Yes	rformed?	death? 1 ☐ Ye	s 2 No
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check onl			
of		. To	1 ☐ Yes 2 X No  27. Manner of Death	28a. Date of Inju	iry	ER/Outpatier 28b. Time o		28c. injury Work	4 🗀 Nui		ne 5 <b>X</b> □Re 28d Describ		6 □Other (Sp v occurred	ecify)
o	Attending Ir death. ector: After by the funer	tlor	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	y Year)	Injury	М		? ′es 2 ☐ N			,		
Division	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At ho	me, farm, sti	reet, factor	y, office		1		(Street an		Rural Route Number,
ō	tel or Att	Cert	4 C HOTHIGO	building, et	c. (opecii)	·/					Only of 1	Own, State	"	
	To the Hospitel or within 24 hours after To the Funerel Dillicompletely filled in	edical	(Check only 2 Medical Exami	sician: To the best ner: On the basis o	f examinal	wledge, deat	h occurred vestigation	at the tim	e, date and inion, death	place, a	and due to the	e, date and	and manner a	as stated. ue to the cause(s)
	To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner st	ated.			c. License				<del></del>		nth, Day, Year)
	_		255. Signature and title of Certifier	1	-			0060				Į.	-	6, 2004
	10		30. Name and address of person who co	ompleted these of a	leath (Item	23a) (Type	Print)							
						North		lway 1	Baltir	more	, Mary	land	21231	
	Sta		31. Date filed (Month, Day, Year)	32. Registr				aks						
	Reaistr	ar	JAN GI/III	14 /		100	11.04.1	12002						

	1 - State Registrar	State of Marylar		rtificate of		F	Reg. No.	200	4 03
	1. Decedent's Name (First, Middle, Last)	)				2. Date of Dea Month	ith Day	Year	3. Time of D
ian ical	ROSE	MILLER				JANUARY	14,	2004	2210
ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deatl	n	4c.	County of Deer	th
	SUBURBAN HOSPITAL			BETHESDA	If Under 24 Hrs.	100 mm ( Pint		NTGOMER	
	5. Social Security Number 6. Set	TM 2171 F	V	Months Days	Hours Min.	(Month, Day	r, Year)	9. Bin	thplace (State or I
	164-14-0552 Usual Residence of Decedent	8	4 Yrs.			MAY 18,	19.	19 PEN	NSYLVANI
	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City
ō	MARYLAND MONTGOMER	RY BETH	HESDA						1X Yes 2
rec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	ountry?
To Be Completed by Funeral Director	5225 POOKS HILL RO	OAD APT. 11291	N	20814			U.S	.A.	
ner	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (S an. Mexican, Puerl	pecify Yes or No-		14. Race - Ame Black, Whit	
교	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:			Specify: WH	
d by	3 Widowed 4 □ Divorced	Year or Dates:							
Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Ki	nd of Business	/Industry
шb	Elementary/Secondary (0-12)	College (1-4or 5+)	1		2)		RET	ATT	
ပိ	11 17. Father's Name (First, Middle, Last)		SALES	S CLERK	18. Mother's Nar	ne (First, Middle,			
Be		OLENSKY			LIZZIE			ROSEN	IBFRG
၉	DAVID  19a. Informant's Name/Relationship (T)		19b. Maili	ing Address (Street		ıral Route Numbe	r, City o		
	BOB P. MILLER/SON	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		POTOMAC					
	20a. Method of Disposition	20b.	Place of Dispe	osition (Name of		Date		cation - City or	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	demoval from State	-	matory or other plac		8/2004	DOCI	7 <b>77</b> 777 E	MARYLAN
	21. Signature of Funeral Service Licens			MEM. PARK 2. Name and Addre		0/2004	KUCI	XVILLE,	MAKIDAN
	1 manda	LUDOLITO	EI	OWARD SAG 191 ROCKV	EL FUNER	AL DIRECT	LION	, INC. , MD 20	1852
	23a. Part1. Enter the disease, or compl	lications that caused the dea						, FID AC	Approximate
	shock, or heart failure. List only of Immediate Cause (Final								Onset and De
	disease or condition resulting in death)	a VENTRICULAR  Due to (or as a consec		LLATION					2 HOURS
		b ACUTE MYOCAL		ISCHEMTA					3 HOURS
je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec							
Examiner	Cause (Disease or injury that initiated events	ACUTE CORONA	ARY OC	CLUSION					3 HOURS
	resulting in death) Last	Due to (or as a consec	quence of):						
cai		d							
Jed	IF FEMALE:								
Physician/Medi	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3[	☐Ectopic pregnancy	y		1	23d. Date of de Month	livery Day Ye
Sici	in the past 12 months? 1 □ Yes 2 ☒ No	4☐Pregnant at time of a	death 5[	Other (specify)					50,
Phy	9 Unknown				on in Dard I	220 Did to	basso u	ica cantributa t	o the cause of dea
b	Part II. Other significant conditions co	intributing to death but not re-	sulling in the t	andenying cause giv	on in Faiti.		es 2		robably 4 Un
ted								Δ.	
ompleted						24a. Was a autop	SV	prior to	utopsy findings av completion of cau
						1 ☐ Yes	rmed? 2∭ No	death?	2 □ No
S	25. Was case referred to medical	Unanital:		0#		ath (Check only or	ne)		
Ве Соп	examiner?	Hospital: 1 ☐ Inpatient 2 5	ER/Outpatie	HIL JU DOA		lome 5 ☐ Resid			ecify)
To Be C	1 ☐ Yes 2 € No	20- Osta et laire.	28b. Time o	Wo	rk? Yes 2 □ No	28d. Describe h	iow injur	y occurred	
To Be C	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		192 5 140		Timot an	d Number or C	ural Route Numbe
To Be C	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)				286 1 position /6			DIZI HOULO NUITIO
To Be C	1 Yes 2 No  27. Manner of Death 1 Notural 5 Pending 2 Accident investigation	(Month, Day Year)	nome, farm, st			28f. Location (S City or Tow			
Certification: To Be C	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At houlding, etc. (Speci	nome, farm, st	treet, factory, office	me, date and place	City or Tow	m, State	)	e stated
Certification: To Be C	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Spectivations: To the best of my kniner: On the basis of examin	nome, farm, st	treet, factory, office		City or Tow	m, State	and manner as	
ertification: To Be C	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physics	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Specials)  ysician: To the best of my kn	nome, farm, st	treet, factory, office	opinion, death occi	e, and due to the curred at the time, o	m, State cause(s) date and	and manner as	e to the cause(s)
edical Certification: To Be C	1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Spectivations: To the best of my kniner: On the basis of examin	nome, farm, st	the occurred at the timestigation, in my o	ppinion, death occi	City or Tow	cause(s) date and	and manner a: I place, and due	th, Day, Year)
edical Certification: To Be C	1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of gertifier	28e. Place of Injury - At he building, etc. (Spectysician: To the best of my kniner: On the basis of examinand manner stated.	nome, farm, st ify) owledge, dea ation and/or in	th occurred at the timestigation, in my control of the control of	ppinion, death occi	City or Tow	cause(s) date and	and manner as I place, and due	th, Day, Year)
edical Certification: To Be C	1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	(Month, Day Year)  28e. Place of Injury - At he building, etc. (Special Special  owledge, dea ation and/or in 23a) (Type	th occurred at the tinvestigation, in my of the second of	ppinion, death occi se number	e, and due to the curred at the time, c	cause(s) date and 29d. Dat	and manner a: I place, and due	th, Day, Year)	

			1 - State Registrar	State of Maryl		artment of I <i>rtificate of</i>			ene 20 (	03897
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		MICHAEL	O. MILLER				JAN 15,	2004	13:28 M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of D	eath	4c. County of	Death
	<b>-</b>		SHADY GROVE HOSPITA			210	CKVILLE			TGOMERY
	Funeral		5. Social Security Number 6. Sex	M 2 F	yrs. last birthday) Yrs.	If Under 1 Year Months Days		Ain. (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	65	110.			3/11/19	38	MASS.
	land ow		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Many Ff sh	tor	MARYLAND MONTGOME	RY	F	ROCKVILLE				ty∏Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?
	23a (23a)	aic	4 DON MILLS COURT				850		U.S.	
9	be filed within 72 hours after death with the Maryland tal Hygiene.  al Hygiene of other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, I to Medical Exam. ar must be notified at	by Funerai	1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	į	Was Decedent of If Yes, specify Cut  1 ☐ Yes 2 2 No		? (Specify Yes or No- uerto Rican, etc.)	Black,	American Indian, White, etc. WHITE
Ö	hours tural		3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occu	pation		6b. Kind of Busi	ness/Industry
Ċ	in 72 n na	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	durina most of			,
212	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	JUDGE	3			FEDERAL	GOVERNMENT
D	other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, M	faiden Surname)	
<u>a</u>	ould be Mental arked o	To B	MAX	MILLER			MOLLIE		KI	RUGER
altimore, Maryland 21215-0036	es 1 and 2 should be filed within of Health and Mental Hygiene. I flem 27 is marked other than r other traumatic event, I'm M	Ċ	19a. Informant's Name/Relationship (Type	oe, Print)		3		r Rural Route Number,		
≥,	and ealth m 27		CAROL MILLER/WIFE		A PROPERTY.		JUKI, K	OCKVILLE,		
ore	Pages 1 nent of H int: If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		Ob. Place of Dispo cemetery, crea	matory or other pla	ice)			ity or Town, State
Ē	tant:		'4 □ Donation 15 □ Other (Specify)			TAN CREM				IA, VIRGINIA
Ba	Department of important: If it any injury or once.		21. Signature of Funeral Service License		110	091 ROCKV	ILLE PI	ERAL DIRECT KE, ROCKVI	LLE, MAI	RYLAND 20852
がある。	Physician		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		ter the mode of dy	ing, s <i>u</i> ch as car	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
****	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a cor	nsequence of):					
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	death certificate be executed e attending physicien and od for use as the burial-transi	dical Ex	resoluting in obdatily East	Due to (or as a cor	isequence or):					
9	ertifica ling pl	Med	IF FEMALE:	To liture outcome of pr						
.O. Box	that the death certific ed by the attending p detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	3c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	ey .		23d. Date Month	
م ٔ	Se UE	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	inderlying cause gr	ven in Part I.	- 11		ute to the cause of death?  ☐ Probably 4 ☐ Unknown
Ö	w require been sig should b	ete						24a. Was ar	24b We	ere autopsy findings available
э Жес		Completed						autopsy perform	prided? dea	or to completion of cause of ath?  Yes 2 No
<u> </u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		ot ot	har	Death (Check only one		(0
ō	Phys r this ral di	To	1 Yes 2 No	28a. Date of Injury	2 ER/Outpaties 28b. Time of	nt 3L DOA	4 U NUISII	ng Home 5 Resider		
O	ding th. : Afte fune	tion	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		ork? ]Yes 2 □ No			
Division of Vital Records,	sl or Attending P after death. I Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filted in	Medical C		sician: To the best of my ner: On the basis of exa- and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (	Month, Day, Year)
16	0		Leshoro	> M.D		D60	0557	To	enuary	15, 2004
6	2 10		30. Name and address of person who co	mpleted cause of death		Print)			1	20850
			DR? LEO SHUE, SHAI	OY GROVE AD	VENTIST	HOSPITAL	, 9901	MEDICAL CEN	TER WAY	, ROCKVILLE, MI
3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	Som 4	11			

			State Registrar AMEND#1perMD1/29/0	te of Maryland		rtment o				giene 2	004	03	898
ı			1 Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Yeer	3. Time of	Death
	Physicia /Medic	_	Louise Plede	ger Meyer • Moyer					January		2004	6:30	A. M
Ł	Examin		4a. Fecility Name (If not institution, give street a	and number)		4b. City, To	wn, or Location	ion of Death		4c. Count	y of Death		
ip			Wilson Health Care Co			Gaith	nersbu	rg ider 24 Hrs.			ontgom		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	Months D		irs Min.	8. Date of Birtl (Month, Day	, Year)	Coun		_
ŢA.	Director		217-36-9799 Usual Residence of Decedent	92	1.0.				Aug. 11	, 1911	North	i caro.	lina_
	No man	İ	10a. State 10b. County	10c. City, T	own or Lo	cation					10	0d. Inside Cit	•
	Man,	to	Maryland Montgomery	Gat	ther	sburg						1 🔀 Yes	2 No
	or 284	Director	10e. Street and Number			10f. Zip Co	ode			10g. Cilizen of	Whal Coun	try?	
	23a		301 Russell Avenue			_	0877			United			
,	tems terms	Funerai	Arr	ns Decedent Ever in U.S. med Forces?	13. V	Vas Deceden Yes, specify	it of Hispanic Cuban, Mex	c Origin? (Spe kican, Puerto	ecify Yes or No- Rican, etc.)	14. Ha	ice - Americ ack, White, o		
9	orl orl	by F	_ If Y	]Yes 2[ <b>X</b> No ′es, Give ar or Date <i>s</i> :	1	☐ Yes 2ॼ	No Spec	city:		Speci	ity: Whi	t o	
3	be filed within 7 c nouts after beain with the maryand tall Hygiene. Ital Hygiene id other than "natural", or Items 23s or 28s-f show event, the Madical Exeminar must be notified at		15. Decedent's Education	1	6a. Deced	leni's Usual C	Occupation			16b. Kind of I		-	
וֹ הַ		Completed	(Specify only highest grade comp	oleted) llege (1-4or 5+)	(Give :	kind of work o	done during r retired)	most of worki	ng				
7	giene er tha	E O	12	1090 (1 401 34)	Sec	retary				Scho			
2	al Hy t other	Be	17. Father's Name (First, Middle, Last)				18. M	lother's Name	e (First, Middle,	Maiden Suma	me)		
2	Ment Ment arkac	2	Charles Edwa						Ava	Harris			_
9	permit. Pages 1 and 2 should be liled within 72 hours after deam with the waryland beginning of Health and Mential Highene. Department if them 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Exeminar must be notified at once.		19a. Informant's Name/Relationship (Type, Pri						al Route Numbe				
≥ . ບົ.	and lealth m 27 her tr		Charles F. Meyer/Son			Box 30			ille, Ma Date	ryland 20c. Location	2176	7 wn Slate	
5	See H See H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova	al from State	etery, cren	natory or othe	er place)						
	Tan tan tan	}	*4 □Donation 5 □ Other (Specify)	Metro	poli	tan Cr	emator	y 1/15	5/2004 \	Alexan	dria,	Virgi	nia
ם מ	Depa Depa Impo eny th		21. Signature of Funeral Service Licenses	1 Carlile					/ol Fune r., Gai			n 208	77
	150200		23a. Part 1. Enter the disease, or complication	s that caused the death.							ilg, n	Approximate	9
			shock, or heart failure. List only one cause immediate Cause (Final	se on each line.	*	1	/	,				Oncet and D	Death
2 <b>- T</b> 9	hysician /Medical		disease or condition resulting in death)	Due to (or as a consequen	ice of):	hear	0	run	re			~ ca	70
ı	Examiner												
#	2 22	ner	cause. Enter Underlying	Due to (or as a consequen	ice of):								
	and trans	Examiner	that initiated events c.	Due to (or as a consequer	and off):								
00,	ate be executed hysician and he burial-transit	cal Ex	rosuming in assum, cast	Due to (or as a consequer	ice or).								
-	physicate the t	-	d										
YO .	ding sding	Physician/Med		es, outcome of pregnance						23d. D	ate of delive	ity	
ם ֹ	atter of for u	ciar	in the past 12 months?	☐Live birth 2 ☐ Fetal de ☐Pregnant at time of deat		]Ectopic pregi ] Other <i>(speci</i>				М	lonth	Day Y	'ear
<b>.</b>	oy the	hysi	9 ☐ Unknown 9L	Unknown									
ν. L	wrequires that the death certifica been signed by the attending ph should be detached for use as th	by P	Part II. Other significant conditions contributi	ng to death but not resulting	ng in the ur	nderlying caus	se given in Pa	Part I.	/	bacco use cor			
Spiosa	equire is uen ould b	ted	Hyperconser	v. Juge	n	- Ca	ord	ve	1 U Y	es 2 ☑No	3   Prob	ably 4 □U	inknown
ວ .	The raw rate has be sage 2 sh	pie	Algheimers	demen	te	e			24a. Was a autop	sy	prior to con	psy findings a apletion of ca	available ause of
		Completed	Peregherals	Ascula	~	ce	ace	<u> </u>	1 Yes		death? 1 🗌 Yes	2 No	
N I G	ysician: is certific director,	Be	25. Was case referred to medical examiner?	ıl·			Othor		(Check only or				
5	Physician: this certific ral director.	7	T Tes 2 INO	I Inpatient 2 LEF	VOutpatien		4 (		me 5 Resid			()	
	ftei ftei	tion	I Material O I ording	a. Dale of Injury (Month, Day Year)	Injury	м	lnjury al Work? 1 ☐ Yes 2	i		,,			
DIVISION	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	a. Place of Injury - At home	e, farm, str	eet, factory, o	office		28f. Location (S		ber or Rura	l Route Numi	ber,
2	after after Dire	Certification:	4 Homicide	building, etc. (Specify)					City or Tow	n, State)			
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: O										
	the H nin 24 the F nplete	Aedi	one) ar	nd manner stated.			icense numb			29d. Date sign			
	To To	Σ	29b. Signature and title of certifier		1					1			na
	0		>14Raheit Dr		-		D 0411	. 5		anua	Ty!	-120	
	Ψ		30. Name and address of person who complete				C	1 a 4 & 1	. a h	MD 20	* 077		
	Sta	te	H. Robert Birschbach, 31. Date filed (Month, Day, Year)	M.D., 201 I		/		artner	sourg,	<u>riD.</u> 200	0//		
	Registr		JAN 2 0 2004	Seneva	19	Spar	KS						

		-	For State Registrar		State of	f Marylan			ment of F <i>ficate of</i>		Mental Hy	giene Reg. No	ZUUL	0389	9
L.	Physicia		Decedent's Name (F								2. Date of De Month	Da		3. Time of Death	
5	/Medic	al	George  4e. Facility Name (If no	C. Merg				4	b. City. Town, o	or Location of Dea	January		2004 County of Deat	1:00 P	
	Examin	٠.	Montgomery						Rockv				Montgome	erv	
30	Funeral	CONT.	5. Social Security Num	ber 6. Se	X	7. Age (In yrs.		N	f Under 1 Year Ionths Days			th y, Year)	9. Birtl	nplace (State or Fore	gn
	Director		187-05-78	97	X M 2□F	83	Yrs.				March 1.	L <b>,</b> 19	20 Penr	isylvania	
	and w	}	Usual Residence of De 10a. State	Ob. County		10c. Cit	y, Town or	Locat	ion					10d. Inside City Limit	
	Maryi	tor	Maryland	Montgom	ery	S	ilve	r S	pring					1 X Yes 2 □ N	lo
	h the	Directo	10e. Street and Number	er					10f. Zip Code			10g. Ci	tizen of What Co	untry?	
	th wit	alD	10801 Mar	gate Roa	.d				20901				ted Star		
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or itema 23a or 28a-f ehow event, tre Medical Examinar must be ricilian at event,	by Funeral	11. Marital Status  1 ☐ Never Married  3 ☒ Widowed 4 [		12. Was Dece Armed Fo 1 X Yes If Yes, Giv Year or D	2 ∏ No ve τ.π.τ⊤:			s Decedent of I es, specify Cub Yes 2\(\overline{\Omega}\) No		Specify Yes or No rto Rican, etc.)	)-	14. Race - Ame Black, White Specify: W		
21215-0036	2 hou atura		15	5. Decedent's Ed	ucation		16a. De	ceden	t's Usual Occup	oation during most of w	odkina	16b. K	ind of Business/	Industry	
212	thin 7	Be Completed	Elementary/Seconda	only highest grad ary (0-12)	College (1	1-4or 5+)	life	. DO	NOT use retire	d)	DIKING	Mas	£o-#	d m o	
7	e filed within al Hygiene. I other than vent, It e Me	Con		-4 46 44 (4)	5		Elec	tri	cal Eng	1	ame (First, Middle		nufactur	ing	_
and	ouid be fi Mental H Marked otl	Be	17. Father's Name (Fit George C		r. Sr.						Klubal	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,		
Maryland	should nd Me mark matic	ဥ	19a. Informant's Name				19b. Ma	ailing /	Address (Street		Rural Route Numb	er, City	or Town, State, Z	Tip Code)	
<u>8</u>	nd 2 still ar ar trau		Lee C. Me:				108	01	Margate	e Road,	Silver S <sub>l</sub>	rin	g, Maryl	and 20901	
altimore,	of Hear item		20a. Method of Dispos		Dameur I from		lace of Dis	spositi remat	on (Name of ory or other pla	ce) Jan	Date uary 23,	20c. L	ocation - City or	Town, State	
Ē	Page nent c ant: #		1 X Burial 2 □ 0  1 4 □ Donation 5			Hi.			emeter	7   20	004	Ros	lyn, Per	nsylvania	
Balt	permit. Pages 1 and 2 should be it Department of Healin and Mental I Important: if item 27 is marked of eny injury or other traumatic ever once.		21. Signature of Fune.	A. Fumply	en	м011	/3	Roc	.kville	, Maryla:	nd 20850	)	phrey Fu omery Av	neral Hom venue,	е,
S	r.		23a. Part1. Enter the shock, or heart f	disease, or compailure. List only	nications that one cause on e	aused the deat each line.	h. Do not	enter t	the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nal	a	kinson's	_	eas	e					years	
6	/Medical Examiner		resulting in death)	(	Due to	(or as a conseq	uence of):								
		-	Sequentially list condi	itions, ediate	b. Due to	(or as a conseq	uence of):	_							
	uted d ansit	Examiner	cause. Enter Underly Cause (Disease or in) that initiated events	ing 2	C						_				
ó	an an	Еха	resulting in death) Las	st	Due to	(or as a conseq	uence of):								
38760,	ficate be executed physician and is the burial-transit	dicai			d										
_	ertifica ding pl	-	IF FEMALE:		23c If yes ou	tcome of pregna	ncv						23d. Date of del	ven/	
P.O. Box	death certifi e attending I od for use as	Physician/M	23b. Was decedent print the past 12 mg	onths?	1 ☐ Live t	ointh 2 ☐ Feta nant at time of d	I death		ctopic pregnand ther (specify) _	ey			Month	Day Year	
o.	0 0 2	ysic	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	40	9□ Unkn				.,,,,						
	The law requires that the tee by the bas been signed by the bage 2 should be detache	by PI	Part II. Other significa		_	eath but not res	ulting in th	e unde	erlying cause gr	ven in Part I.				the cause of death?	
ğ	w require been sig should b	edt	Atrial F	ibrillat	ion						. 10	Yes 2	INo 3 ☐ Pr	obably 4 Unknov	٧n
Division of Vital Records,	e iaw requ has been je 2 shouli	Completed	Dementia								24a. Was auto	DSV	prior to d	topsy findings availate completion of cause of	ole f
œ =	The sate h page	Com									1 Yes	rmed? 2⊠ No	death? 1 ☐ Yes	2□ No	
<u>Zita</u>	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:	07-70-0					eath (Check only		TZ.	The second second	
o	Phya this ral dir	. To	1 ☐ Yes 2 🔯 No 27. Manner of Death	0	1 🗆	Inpatient 2  of Injury	ER/Outpa 28b. Time	_	3 DOA 28c. Inju	4 🗀 Nursing	Home 5 ☐ Resi			city) Hospice	_
on	ding th. After fune	tion		5 Pending investigation		of Injury oth, Day Year)	Injur			nrk? ]Yes 2∐No					
<u>Visi</u>	or Attending after death. Director: After in by the funer	ifica		6 Could not be determined	208. Flau	e of Injury - At h ling, etc. (Specia		stree	t, factory, office		28f. Location ( City or To	Street al	nd Number or Ru	ral Route Number,	
ā	tal or A	Certification;	Tomode		Dolla	mig, cic. (opean					ia .				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		(Check only 2	Certifying Ph	niner On the b	asis of examina	wledge, de	eath o	ccurred at the t stigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s date an	) and manner as d place, and due	stated. to the cause(s)	
	hin 2, the F	Medical	29b. Signature and tit	le of pertifier	and man	nner stated.			29c. Licen	se number		29d. Da	ite signed (Monti	n, Day, Year)	
	Z Will		255. Gigitalore and lit	in him	000)					10050	2		uary 19,		
	1>+1		30. Name and addres	SOLDELSON WHO	completed cau	se of death (Iter	π 23a) (Tvi	pe, Pri	int)	0000	X				
			Joyson Ka	rakunnel						Road, Ro	ockville,	Ma	ryland	20855	
	Sta Registi		31. Date filed (Month,	N 22 2	004 32. F	Registrar's Signa	ature	9	Sport	1					

				•	yland / Depa			•	_		
			1 _ State	State of Ivial	•	tificate of I			g. No. 2 0 0 L	03900	
			Registrar  1. Decedent's Name (First, Middle, Last)			tinoate or i	Journ	2. Date of Death	1	3. Time of Death	
	Physici		William Patrick	McGuire.	Jr.			Month	Day Year	11051 M	
	/Medic Examin		4a. Facility Name (If not institution, give st		<u> </u>	4b. City, Town, or	Location of Death		4c. County of Dea	ath	
	LXuiiiii		Washington Adventi	st Hospit	al	Tako	ma Park		Montgon	nery	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)	
	Director		217-84-2506	281	44 Yrs.			Dec. 29,	1959 V	rginia	
	land		Usual Residence of Decedent  10a. State 10b. County		IOc. City, Town or Lo	cation				10d. Inside City Limits	
	Many	ţō	Maryland Prince (	Correcte	Laurel					1 ☐ Yes 2 ☑ No	
	r 28a	Director	10e. Street and Number	eorge a	Laurer	10f. Zip Code		10	g. Citizen of What C	ountry?	
	th with		24 South Paula Str	reet		20707	7		USA		
	eme erme	Funeral	11. Marital Status	2. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
36	or It	by Ft	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite	
8	within 72 hours after death with the Maryland ene. then "natural", or lieme 23a or 28a-f show the Madiral Examerar must be notified at	q pa	15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry	
5.	in 72 n "na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of world)	king		,	
212	filed withi Hygiene. other then	Completed	12	College (1-401 3+		ervisor			Plumb	ing	
פר	al Hyg	Bec	17. Father's Name (First, Middle, Last)		•		18. Mother's Nam	e (First, Middle, M	faiden Sumame)		
ylaı	2 should be filed w n and Mental Hygie Is marked other traumatic event, In	٦ L	William Patrick M					larie Cor			
Maryland 21215-0036	2 sh and Is m		19a. Informant's Name/Relationship (Typ						City or Town, State,	Zip Code)	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23a or 28a-f show emportant: If item 27 is marked other then "natural; or iteme 23a or 28a-f show employing yo other traumatic event, the Medical Examination must be notified at once.		Lucy Marie King/	Mother	9250 20b. Place of Disponsional Computers, creating the computers of the computer of the compu	Edwards		Date	20c. Location - City or Town, State		
Baltimore,	Department of Hisportant: If ite eny Injury or of once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	Gate of			ary 26			
Ħ	artme ortan		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Fugeral Service License</li> </ul>	e /7	Ceme	tery 2. Name and Addre				ring, Marylan	
Ba	Depar Impor eny Ir		200	V	F1	ancis J. 00 Univer	Collins sitv Blvd	Funeral L. W., Si	Home Inc.	ng, MD 20901	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused to	ne death. Do not ent					Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Diag	111/80	uhni	1000			Onset and Death	
	/Medical		resulting in death)	Due to (or as a	consequence of):	7000	· · · · · · · · · · · · · · · · · · ·				
73	Examiner		Sequentially list conditions, b.	DM	umo	nia					
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Thue to (or as a	consequence of):	N. V-2					
	be executed icien and burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	100					
760,	death certificate be executed e attending physicien and nd for use as the burial-transii	calE	d								
189	leath certificate to attending physicaters										
Вох	n cert anding use a	M/u	23b. Was decedent pregnant	3c. If yes, outcome of 1□Live birth 2		Ectopic pregnancy	,		23d. Date of de	,	
	deati	sicla	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at ti		Other (specify)			Month	Day Year	
P.0	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physiclan/Medl	9 Unknown					02 - Did tah		to the cause of death?	
	res th	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	li la	4		Probably 4 RUnknown	
Ö	w requir been si should	Completed by	Swar Just	au Gu	Mr. Co	COVCO	acraga	cursos		The state of the s	
3ec	has by	Idm	Renal bad	ul				24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of	
al		e Co	2 Was case referred to medical	Malh	4		00.01 1.0	1 ☐ Yes 2		s 2□No	
of Vital Records,	Physician: The lav this certificate has ral director, page 2	0	avaminar?	ospital:	t 2 ER/Outpatier	nt 3 DOA Oth	ar	th (Check only one	nce 6 □Other (Sp	ecity)	
of	는 는 교	n: To	27. Manner of Death	28a. Date of Injury (Month, Day			y at		w injury occurred	oony	
ion	Attending or death.  sector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	(Mornin, Day	roar, injury		Yes 2 □ No				
Division	er de er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Sti City or Town	reet and Number or F , State)	Rural Route Number,	
	ital o irs aft ral Di	Cer									
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination		examination and/or in						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner star	BG.	29c. Licens	e number	29	9d, Date signed (Mor	nth, Day, Year)	
	10			_ [	1/1/	mn	1.00	C-3	1/21/04		
	10		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type.	Print)	001	2)	1 31/	1	
			Deanna White M.D.		arroll Ave		oma Park	MD 20	912	,	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra		Som V	1				

			For State Registrar	State of	Maryland / Depa	artment of F rtificate of			ene 20 (	04 03901
	E Est	Ť	Decedent's Name (First, Middle	e, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic	·-	MUKUT	VEHARI	MATHUR	T		JAN.21,2	2004	6:15 AM
	Examin	er	4a. Fecility Name (# not institution WASHINGTON AD)			4b. City, Town, o	ARK MD		4c. County of MONTGO	
9	Funeral		5. Social Security Number 231–89–2081		7. Age (In yrs. last birthday) 88 Yrs.		-	8. Date of Birth (Month, Day, Y	'ear)	P. Birthplace (State or Foreign Country)  INDIA
1000	Director		Usual Residence of Decedent					JAN. 191	1710	
	arylan ehow del	_	10a. State 10b. County	RFAX	BURKE	ocation				10d. Inside City Limits 1 X Yes 2 □ No
	the Mi	Director	VA FAI  10e. Street and Number		DORKE	10f. Zip Code		100	, Citizen of Wh	
	death with the Maryland ms 23a or 28a-f ehow rmat be notified at	I Di	9913 MANET R	OAD		2201	.5		INDIA	
0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	Armed For	ces? 2 [ <b>X</b> No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White etc ASTAN INDIAN
ה ה	72 ho	etec	15. Deceder (Specify only highe	nt's Education st grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work		b. Kind of Busi	ness/Industry
7	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)	ESSOR	0)		EDUCATI	ON
פר	be filed within tal Hygiene. d other than "	BeC	17. Father's Name (First, Middle,				18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
yland	2 should be and Mental is marked ( raumatic ev	To	SHYAM BEHARI					I MATHUR		
Mary	d 2 shi th and 7 is m traum		19a. Informant's Name/Relations DINESH KUMAR—SO				and Number or Run			
ō,	s 1 an f Heal item 2		20a. Method of Disposition		20b. Place of Disp		01/02			ity or Town, State
Ē	Page In it is		1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other (\$		NORTHERN	VA CREMA	TORY	Al	RLINGTO	•
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic evone.		21. Signature of Funeral Service	Walder	3000		ess of Facility AF			
	*		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on ea	aused the death. Do not enach line.	ter the mode of dyi	ng, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	nanila	in				unthum
	Examiner			Due to (	or as a consequence of):					
		ner	Sequentially list conditions, in a second to cause. Enter Underlying Cause (Disease or injury	b. — Due to (	or as a consequence of):					
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to f	or as a consequence of):					
8760,	ficate be execute physicien and is the burial-trans			333.57	5. 25 2 55.155 <b>4</b> 55.155 5.7.					
Ó	tificate ig phy: as the	ledical		0.						
Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi		⊒Ectopic pregnanc	y		23d. Date	
0.	he dea the al	yslci	1 Yes 2 No	4☐Pregna 9☐Unkno		Other (specify) _				
2	res that the de signed by the a l be detached (	by Ph	Part II. Other significant condit	ions contributing to de	eath but not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	cco use contrib	ute to the cause of death?
rds	w requires been sign should be	ed b	Hypertens	une Car	dovosal	an dr.	rene	1 ☐ Yes	2 <b>D</b> MG 3	Probably 4 Unknown
Vital Records,	e law re has be je 2 sho	Completed	0					24a. Was an autopsy	- Drie	ere autopsy findings available on to completion of cause of
E E	tician: The l certificate he rector, page								No 1E	ath? ]Yes 2□ No
	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 6	npatient 2 ER/Outpatie	nt 3 DOA	ner	h <i>(Check only one)</i> ome 5 ☐ Residen		(Specify)
Division of	neral c	J:uc	27. Manner of Death 1 Natural 5 □ Pend	28a. Date o	of Injury h, Day Year) 28b. Time	of 28c. Inju	ry at rk?	28d. Describe how		
Sio	tendir leath. tor: Af the fu	Certification:		igation	of laive. At home form a		]Yes 2 □No	28f Location (Stro	at and Number	or Rural Route Number,
$\frac{1}{2}$	for At after of Direct	ertif	4 Homicide deten	mined 288. Flace buildir	of Injury - At home, farm, sing, etc. (Specify)	reet, factory, office		City or Town,	State)	oi nuiai noute Nuilloei,
-	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.				best of my knowledge, dea					
	the H hin 24 the F mplete	Medical	29b. Signature and title of certific	and manr	ner stated.		se number			(Month, Day, Year)
}	5 × 5 0	-	Mka	- MD				10		4.1
			30. Name and address of person	who completed caus	e of death (Item, 23a) (Type	Print)	8895 AVE, T	$-\theta$	0	
			MOBARAK	L KAR	M 1010C	PRRULL	AVE, 1	MKOMA	PARK	-, MD 20912
	St Regist	ate rar	31. Date filed (Month, Day, Yea JAN 2		egistrár's Signature	sport				

			State C 1 - State Registrar	of Maryland / Depa Cea	artment of Heal		Hygiene Rag. No. 2	04 03902
	Physicia	20	1. Decedent's Name (First, Middle, Last)			2. Date of Month	Day	3. Time of Death Year
	Physicia /Medic			LaPAZ MARTINE	4b, City, Town, or Loca	JAN	4c. County of	
	Examin	er	4a. Facility Name (If not institution, give street and nu 2812 DENLEY PL.	mber)	SILVER		,	GOMERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If U	nder 24 Hrs. 8. Date of		Birthplace (State or Foreign Country)
	Director		217-45-8033	70 Yrs.	Months Days Ho	urs Min. (Month	7, 1934	EL SALVADOR
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Manyla f sho	ō	MD. MONTGOMERY		SILVER SPRI	NC .		1 X Yes 2 □ No
	r 28a-	irect	10e. Street and Number		10f. Zip Code		10g. Citizen of W	hat Country?
	th with	alD	2812 DENLEY PL.		20906	<b>i</b>	EL SA	LVADOR
	or items	ıner	Armed F	orces?	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify Yes or exican, Puerto Rican, etc.		- American Indian, , White, etc.
36	rs afte	y F	1 ☐ Never Married 2 ▼ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or [	2 X No ive Dates:	1X Yes 2□No Sp	ecity: EL SALVADO	Specify:	WHITE
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene.  ad other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, I're Medical Exartiral must be natified at	Completed by Funeral Director	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Bus	
215	within 7: ene. than "n	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (	life.	kind of work done during DO NOT use retired)	-		
2	e filed wil al Hygien other th vent, the	Con	1		HOMEMAKER	Mother's Name (First, Mid	tale Maiden Sumana	HOME
Maryland	tbe fill	Be	17. Father's Name (First, Middle, Last)	EMBEG	18. F			
Ĭ	should be nd Mental markad martic ev	욘	VICENTE MEI  19a. Informant's Name/Relationship (Type, Print)	LENDES 19b. Mailir	ng Address (Street and N	CLEOTIL lumber or Rural Route Nu		
Σ	nd 2 still ar ar 1st reu		JOSE MARTINEZ/SON	2812	DENLEY PL.	, SILVER SP	RING, MD.	20906
ore,	of Hez		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cree		Date		City or Town, State
<u><u>E</u></u>	Page Tient ant: If		'4 □Donation 5 □ Other (Specify)	GATE OF	HEAVEN CEM.			SPRING, MD.
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 Is marked any injury or other traumatic e once.		21. Signature of Funeral Service Licensee	M00091 CF	2. Name and Address of I HAMBERS FUNE BO1 CLEVELAN	Facility CRAL HOME & ID AVE., RIV	CREMATORIU ERDALE, ME	M,P.A. 20737
h	Pnysician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Do not enteach lineSMALL CELL LU		ch as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death 7 MONTHS
	/Medical Examiner		resulting in death)  Due to	(or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate causa. Entat Ur Janying Cause (Disease or injury	(or as a consequence of):				
	cate be executed physician and s the burial-transit	Examiner	that initiated events c.					
8760,	oe execian a	E EX	Due to	(or as a consequence of):				
387	physics the t	dicai	d					
Box 6	death certificate e attending phys of for use as the	Physician/Med		tcome of pregnancy	75		23d. Date	of delivery
	death e atte	icia	in the nact 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		Mon	th Day Year
P.0	that the ded by the	Phys	9 Unknown			220 5	Vid tabassa usa santri	bute to the cause of death?
Vital Records,	es be pe	þ	Part II. Other significant conditions contributing to o	leath but not resulting in the u	nderlying cause given in			B Probably 4 Unknown
000	> 11 0	Completed				24a. V	Was an 24b. W	ere autopsy findings available for to completion of cause of
Ä	0 5 0	шo				n	erformed?   de	eath? □Yes 2□No
/ita	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			Place of Death (Check or	nly one)	
of <	this aldi	ဥ	1 ☐ Yes 2 X No	Inpatient 2 EP/Outpatier of Injury 28b. Time o		□ Nursing Home 5X F	lesidence 6 Othe	
no	Ing	tion	A matural	of Injury oth, Day Year) 28b. Time o Injury	Work? M 1 ☐ Yes	_	Bo now injury cooding	
Division	ne Hospital or Attending F n 24 hours after death. ne Funeral Director: After pletely filled in by the funera	ertification;	3 Suicide 6 Could not be	e of Injury - At home, farm, str ling, etc. (Specify)	reet, factory, office		on (Street and Numbe Town, State)	r or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in	O	29a. Certifier	e best of my knowledge, deat	h occurred at the time, da	ate and place, and due to	the cause(s) and man	ner as stated.
	the Hos of 24 hir the Fun hpletely	edicai	(Check only 2 Madical Examiner: On the l	pasis of examination and/or in oner stated.	vestigation, in my opinion	n, death occurred at the tir	ne, date and place, a	nd due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	. ^	29c. License num	nber	29d. Date signed	(Month, Day, Year)
•			Jam James	y Mel.	D5382	29	JAN.	21, 2004
			30. Name and address of person who completed cau			R DR.#205, G	REENBELT.	MD. 20770
	Sta	ite	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	Sparks	- Dict # 2009 0		
	Registr	ar	JAN 22 2004	sereva B	Popular			

		-	For State Registrar	State of Maryland / [		ent of Hea ate of De		ental Hygie Reg	2004	03903
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia		DELOISE	MARR					Day Year 7 . 2004	3:45A M
Ē	/Medic Examin	_	4a. Facility Name (If not institution, give si		4b. 0	City, Town, or Loc	ation of Death		4c. County of Death	
			102 Ritchie A	venue	S	ilver S			Montgom	ery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Mon		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign Try) Yland
	Director		220-40-6666	M <b>%</b> F 69	Yrs.			(Month, Day, Y May 21,	1934 Mar	yland
	p ,	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Location					Od. Inside City Limits
	anyla shov	_				Spring	ſ			1 XYes 2 ☐ No
	M er 189 -1	Director		iery 5.		. Zip Code		100	. Citizen of What Cou	ntry?
	with the		10e. Street and Number 102 Ritchie Av	zenue	100		910	1,09	U.S.A.	,
	d within 72 hours after death with the Maryland speed. I than "natural", or Items 23a or 28a-f show the Medical Evant or must be notified at	Funerai		2. Was Decedent Ever in U.S.	13 Was D	ecedent of Hispar	nic Origin? (Spe	cify Yes or No-	14. Race - Ameri	can Indian,
	after de or Item	Ě	11. Marital Status  1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	If Yes,	specify Cuban, M	lexican, Puerto f	Rican, etc.)	Black, White,	
و	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 2X No S	pecify:		Specify: B.	lack
2-003e	72 hours 'natural', Ilcal Ern		15. Decedent's Educ		. Decedent's	Jsual Occupation	n most of working	16	b. Kind of Business/Ir	dustry
2	within 7, ene. than "n	e e	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		f work done durin T use retired)	g most of workin	'y		
7	d with	Completed	11th		Hou	sewife			Home	
	be filed vital Hygie od other is avent, the	Be (	17. Father's Name (First, Middle, Last)			18.		(First, Middle, Ma		
Vian	Ment Ment arkec arkec	2	Lee A. Jordo					elen Wai		
a	and and lam.		19a. Informant's Name/Relationship (Typ		_				Crasina	
2	es 1 and 2 should be of Health and Mental f itam 27 la marked or r other traumatic av		James W. Marr		TUZ R				c. Location · City or T	MD 20910
more,	To H is		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ery, crematory	or other place)				
Ē	Fag ment tent: jury		`4 □Donation 5 □Other (Specify)			ial Cem			Sandy Spi	
ga	permit. Pages 1 Department of F Importent: If its any Injury or ot		21. Signature of Funeral Service License	An nuttou					uneral Ho	MD 20850
	40244		23a. Part 1. Enter the disease, or compile	entions that caused the death. Do					<del> </del>	Approximate
			shock, or heart fallure. List only on	e cause on each line.	THOSE GENERAL STATE	mode or aying, or	2017 20 02 02 0			Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Cardiopul		y Arres	st			
	/Medical Examiner			Due to (or as a consequence						
		<u>~</u>	Sequentially list conditions, if any, leading to immediate	Lung Canc  Due to (or as a consequence						
	ned Insit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	execun and and ial-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	of):					
9/8	death certificate be executed e attending physician and nd for use as the burial-transit	dicai	<b>U</b> ₀							
8	ifficat g phy as th	ed								
ŘOX	eath certifica attending pt I for use as t	N/	23b. Was decedent pregnant	lc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	h 3□Ectop	ic pregnancy			23d. Date of deliv	ery Dav Year
	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death		r (specify)			Worth	Day 10ai
J.	at the by th	Physician/Med	9 🗆 Unknown					00a Didasha	cco use contribute to	ha cause of death?
	requires that the de een signed by the a hould be detached f	þ	Part II. Other significant conditions con Brain Metas		in the underly	ng cause given in	1 Paπ 1.			pably 45 Unknown
ğ	w require been sig should t	ted	Brain Metas	Lasis				1 .63	-,-	
ပို	~ Q 70	ple						24a. Was an autopsy	24b. Were autoprior to co	opsy findings available impletion of cause of
<u>~</u>	The ate ha	Completed						performe 1 ☐ Yes 2 5	No 1 Yes	2□ No
Vital Records,	sician: The law certificate has irector, page 2 s	Be	25. Was case referred to medical examiner?	ognital:		Other		(Check only one)		
_	Physi this c	ို		· · · · · · · · · · · · · · · · · · ·	outpatient 3	J DOA .		ne 5 🔀 Residence 28d. Describe how	be 6 Other (Speci	(y)
Ĕ	ing F	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending		Injury	28c. Injury at Work?	2□No	ada. Doscribo non	injury occurred	
<u>s</u>	ttand death stor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury · At home, f				28f. Location (Stree	et and Number or Rur	al Route Number,
Division of	pital or Attanding Pours after death. Inaral Director: After titled in by the funera	Certification:	4 Homicide determined	building, etc. (Specify)	,	,		City or Town,	State)	
	spital lours naral		29a. Certifier 1 ₩ Certifying Phys	ician: To the best of my knowledg	ge, death occu	rred at the time, o	date and place, a	and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	(Check only 2 Medical Examir one)	er: On the basis of examination a and manner stated.	ind/or investiga	ation, in my opinio	on, death occurre	ed at the time, date	and place, and due	o the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifier			29c. License nu	mber	290	Date signed (Month)	Day, Year)
	7						614		1/20/0	4
	5		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	1 7	# 20 E	ma learne	Daris N	ID 20912
		1	Nasreen Kango		arrol	I Ave.,	, #ZUS,	, Takome	= ralk, r	ID 20312
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 22 200	32. Degistrar's Signature	5 1	oaks				

State of Maryland / Department of Health and Mental Hygiene 🤈 03904 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 19, 2004 ам January 5:40 Vincent A. Mariner /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 117 M 2□ F Dec. 18. 1926 Washington, DC 577-30-5638 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location Items 23a or 28a-f show Examiner count be notified at 1 ☐ Yes 2 XNo Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 20904 USA 3126 Gracefield Road, Berkshire Gardens death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after adment of Health and Mental Hygiene. ortant: if Item 27 is marked other than "natural", or ite injury go other traumatic event, the Medical Examina 8. 1 ☐ Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Systems Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Lee Mariner Ester Catherine Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia W. Mariner/ Wife 3126 Gracefield Rd., Berkshire Gardens #221, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 20 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State permit. Page Department of Important: If any Injury og \* 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 2004 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee WILDERACE 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction Days /Medical Due to (or as a consequence of): **Examiner** Years Dilated Cardiomyopathy Sequentially list or aftices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Multi-Organ Failure Days Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown signed by tild be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director; / completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A. Nama> 1-19-04 D50987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 83819 Gailhersburg PO BOX NAWA NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21 2 meron Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] 03905 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 16, 2004 **Physician** 8:20 Ам Virginia Ann Magruder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Hours Min. 1 ☐ M 2 🖾 F 1942 Washington, D.C. 61 July 28, 216-40-8051 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County il Hygiene. I other then "natural", or Itama 23a or 28a-1 anddoni, tra Medical Examitrer must be notified at 1 ☐ Yes 2 X No Bethesda Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code United States 20814 5305 King Charles Way death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 5+ Procurement other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hight If item 27 is marked oth Be Frances Reed Hoburg Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5523 Wicomico Drive, New Market, Maryland 21774 Philip Garvey /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition January 23 permit. Pages Department of Important: If it any injury or o Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 2004 \* 4 □ Donation 5 □ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 21. Signature of Fureral Service Licensee M01305 23a. Part Lefter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Staphylococcal Sepsis resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Steroid Dependent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Chronic Obstructive Airway Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician by Physician/Medical the attending f IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 🔀 No the Division of Vital Records, P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed pp Hypertension, Anxiety-Depression 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2X No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \( \triangle \text{ Nursing Home} \) 5 \( \triangle \text{ Residence} \) 6 \( \triangle \text{Other} \( (Specify) \) 1 ☐ Yes 2 X No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral D pelii 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier January 20, 2004 D23170 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9406 Old Georgetown Road, Bethesda, Maryland 20814 Gita Bakshi, M.D. 31. Date filed (Month, Day, Year)

JAN 22 2004 32. Registrar's Signature State sacker

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.1

			1 - For State Registrar		State C	n Marylar		tificate c	f Death		Reg	J. No.	UU4	U3906
	Physicia	an	1. Decedent's Nan	ne (First, Middle							Date of Death Month	Day	Year	3. Time of Death 7:50P M
	/Medic	al	4a Facility Name	MELV	N F.	MARG	OLIN	4b City Town	n, or Location of I		ANUARY		2004 unty of Deeth	
	Examin	er			JRSING HO				(VILLE				NTGOME	
	Funeral		5. Social Security		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24	Hrs. 8.	Date of Birth (Month, Day, )			place (State or Foreign intry)
	Director		568-09-89		1 <b>∑</b> M 2□ F	84	Yrs.	Months	110013		INE 6.			LIFORNIA
Т	and W		Usual Residence	of Decedent 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow	tor	MARYLAND	MONTO	COMERY		POTOMA	AC.						1 → Yes 2 □ No
	r 28a	Director	10e. Street and No	umber				10f. Zip Cod	θ		10	g. Citizen	of What Cou	ntry?
	th with		#2 OLD	CREEK (	COURT				20854			TED :	STATES	OF AMERICA
	after death w or Iteme 23a	Funeral	11. Marital Status		Armed F	edent Ever in U orces?	J.S. 13.	Was Decedent of Yes, specify C	of Hispanic Origin Juban, Mexican, I	n? (Specify Puerto Rica	Yes or No- an, etc.)		Race - Ameri Black, White,	
0000	s afte	by Fu		rried 2X Marr 4 Divorced	ied 1 X Yes If Yes, G	2□N%ARM ive DateWWII	Y	1 □ Yes 2 👿	No Specify:			Spe	ecity: W	HITE
3	within 72 hours after des ane. then "natural", or Iteme he Moulcal Exertimer to			15. Deceden	t's Education		16a, Deced	ient's Usual Oc	cupation	of completes as	10	Sb. Kind o	of Business/Ir	ndustry
2		Completed	(Specification)		t grade completed) College (	1-4or 5+)	life.	DO NOT use re	ne during most o tired)	or working				
4	be filed withital Hygiene. d other then	Соп			4		SEN	OR VICE	E PRESID					ANUFACTURING
2	be fill d ofth	0	17. Father's Name								irst, Middle, Ma	aiden Sur	name)	
7	should be nd Mental marked c	၉	19a. Informant's N	M.J. MAI			19h Mailir	o Address (Str	eet and Number		MEDVIN	City or To	wn State Zi	o Code)
<u>z</u>	nd 2 s lith an 27 le i		1		N - DAUGH	TER	1 -2		COURT,					,
ע	Hea Item		20a. Method of Di	sposition		20b. I	Place of Dispo	sition (Name of natory or other		Date			on - City or T	own, State
	Page nent o int: If		1 X Burial 2 `4 □ Donation	2 □ Cremation 5 □ Other (S	3 □Removal from pecify)	State	•		RANCE 0	1/19/	'04 C	LARKS	SBURG,	MD
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 ie marked eny Injury or other traumatic evonce.		21. Signature of F	uneral Service	Licensee		EI 10	Name and Ad	dress of Facility AGEL FUN VILLE P	ERAL	DIRECT	ION,	INC.	852
	₹.		23a. Part1. Enter	the disease, or	complications that only one cause on	caused the dea							110 20	Approximate Interval Between
<b>3</b> 21	Physician		Immediate Cause disease or condit	(Final	•	STAGE R	ENAT. DI	SEASE						Onset and Death
	/Medical		resulting in death	)	a	(or as a consec								
	Examiner		Sequentially list of	conditions.	D	RTENSIV		DISEAS	SE					
٠	ed sit	lne	Sequentially list of if any, leading to cause. Enter Und Cause (Disease of	derlying	•	(or as a consec		TRACE						
	and al-tran	Examlner	that initiated even	its	C	(or as a consec		DEASE						
00/00	lficate be executed g physicien and as the burial-transit				L <sub>d</sub>									
00	= 00 00	ledical												
200	death certi e attending ed for use a	Iclan/M	IF FEMALE: 23b. Was decede			utcome of pregn birth 2 ☐ Feta		Ectopic pregna	incy			23d.	Date of delive	rery Day Year
	0 0 0	sici	in the past 1 1 Yes 2 9 Unknow	No		nant at time of		Other (specify	)				WOTH	Day 10a1
Ţ.	requires that the de een signed by the a hould be detached f	Physi			ons contributing to	death but not re:	sulting in the u	nderiving cause	given in Part I.		23e. Did toba	cco use	contribute to	the cause of death?
Š,	signe d be	d by	, carrier and		<b>3</b>			, ,			1 🗆 Yes	2 🗆 N	o 3 🗆 Pro	bably 4 Unknown
200	> D 0	ompleted									24a. Was an	2.	4b. Were aut	opsy findings available
ב	has has	duic									autopsy perform	ed?	prior to co death?	ompletion of cause of
Vilai	sician: Th certificate rector, pag	O	25. Was case refe	erred to medica	, , , , , , , , , , , , , , , , , , , ,				26. Place o	of Death (C	1 ☐ Yes 2		1 ∐ Yes	23.70
	g .⊵ 5	To B	examiner? 1 ☐ Yes 2	No No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3□ DOA	Other: 4 XNurs	sing Home	5 Residen	ce 6 🗆	Other (Speci	(fy)
5	ding Ph h. After th funeral		27. Manner of De	ath 5 🗌 Pendir	28a. Date (Moi	of Injury oth, Day Year)	28b. Time o Injury	1	njury at Work?		. Describe how	injury od	curred	
20	Attsnding redeath.	catl	2 Accident 3 ☐ Suicide	investi 6 ☐ Could	gation not be	n of latings. As h			I □ Yes 2 □ No		Location (Stre	et and M	umber or Rus	al Route Number,
	2 = = -	Certification:	4 Homicide	datam	ined 200. Flac	e of Injury - At h ding, etc. (Speci	ify)	eet, ractory, on	u <del>o</del>	201.	City or Town,		uniugi Oi Mül	a riodo rulloo,
_	Hospite 14 hours Funera tely lille	Medical Co	29a. Certifier (Check only one)	1X Certifyir 2 Medicel	ng Physician: To the	basis of examin	owledge, deat ation and/or in	n occurred at th	e time, date and ny opinion, death	place, and occurred a	due to the cau at the time, dat	ise(s) and e and pla	d manner as a	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature ac	nd title of certifie		nner stated.		29c. Lic	ense number		290	d. Date si	gned (Month,	Day, Year)
	i ~			mom		· Nosy	nu.	T	047330			TANT	<b>1</b> ∆₽∇ 16	9,_2004
	10		30. Name and ad		who completed cau	use of death (Ite	т 23а) (Туре,		741 930			DAME	WILL I	2, 2004
			THOMAS	JOSEPH	MD, 50	W EDMO	NSTON I		ROCKVILL	E, MD	20852			
N	Sta		31. Date filed (Mo	JAN 22	32.	Registrar's Sign	nature /	Spore						
	<ul> <li>Registi</li> </ul>	al		JULIA WW	LUUT /	7		//						

		•	For State Registrar	State of	Marylan		artment of tificate of				giene Reg. No.	2004	03907
			1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic		SAMUEL C. MARCUS							JANUAR	Y 19,	2004	1615 M
	Examin	er	4a. Facility Name (If not institution, given				4b. City, Town,	, or Location	ol Death		1	County of Deat	
			MONTGOMERY GENERA  5. Social Security Number 6.5		'AL 7. Age (In yrs.	last birthday)	OLNEY  If Under 1 Yea	r If Unde	r 24 Hrs.	8. Date of Birl	th	TGOMERY 9. Bird	
	Funeral Director			1∑M 2□F	85		Months Day	s Hours	Min	(Month, De IAY 24,	v. Year)	8 PENN	hplece (Stete or Foreign untry) SYLVANIA
			Usual Residence of Decedent		100 63								10d Incide City Limite
	show	5	10a. State 10b. County			y, Town or Lo	Cation						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N	ect	MARYLAND   MONTGOM  10e. Street and Number	ERY	ROC	KVILLE	10f. Zip Code	)			10a, Citiz	zen of What Co	untry?
	3a or		13417 KEATING STR	EET			20853			1	U.S.A	A.	
	death	Funeral Director	11. Marital Status	· ·	dent Ever in U.	.S. 13. \	Was Decedent of f Yes, specify Cu	f Hispanic O	rigin? (Spec	cify Yes or No Rican, etc.)	- 1	14. Race - Ame Black, White	
9	hours after death with the Maryland tural; or Items 23a or 28a-f show al Ezamir or Inust be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes	2 🗆 No		1□Yes 2⊠N	o Specify	<i>/</i> :				HITE
200	tural		15. Decedent's E	ducation	ites:WWII	16a. Deced	dent's Usual Occ	upation			16b. Kir	nd of Business/	Industry
<u> </u>	hin 72 a. na Medis	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-	-4or 5+)	(Give	kind of work don DO NOT use reti	ie during mo red)	st of workin	ig			
7	ed wit	Completed		4		BIOST	ATATICIA					GOVERN	MENT
yıand	be file	Be	17. Father's Name (First, Middle, Last							(First, Middle,	Maiden .		D
Ž	hould d Mer marke matic	ဥ	I SAAC  19a. Informant's Name/Relationship	MARCUS	5	19b. Mailir	ng Address (Stre	JENN et and Numb		Route Number	er. City or	WEINE	
Z	nd 2 s lith an 27 is r trau		RUTH A. MARCUS/WI				KEATIN(						
e,	of Hear		20a. Method of Disposition		20b. F	Place of Dispo	sition (Neme of natory or other p	lace)	Da	ate	20c. Lo	cation - City or	Town, State
Ē	Page ment of uny or		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		State	KLAWN	MENORAH	GDNS					MARYLAND
Daitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. I important: If than 27 is marked other then "natural", or tems 23e or 28e-1 show eny injury or other traumatic event, the Medical Examination must be notified at once.		21. Signature of Funeral Service Lice	State	Harris	C3_11	Name and Add NZANSKY- 70 ROCKV	VILLE	PIKE,	ROCK V	LLLE,	APELS, MARYL	INC. AND 20852
ľ	表		23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on ea	aused the leat	h. Do not ent	er the mode of d	ying, such a	s cardiac or	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediete Cause (Final disease or condition										Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a conseq	uence ol):	1NFE	1117	100				
Н	And Anguard State	er	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a conseq	uence ol):	1041						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Ď,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (	or as a conseq	uence ol):							
08/PU		dlcal	•	d									
X O C	death certifi e attending id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pregnar				2	3d. Date of deli	ivery
	s death he atte ed for	Physician/M	in the past 12 months? 1 Yes 2 No		ant at time of d		Other (specify)					Month	Day Year
r Ö	d by th	Phy	9 Unknown  Part II, Other significent conditions			ulting in the u	nderhing cause	gwen in Part	1	23e Did t	obacco u	se contribute to	the cause of death?
ds,	w requires that the death certif been signed by the attending should be detached for use a:	d by	DM	oorning to do		g	,	9					obably 4 Unknown
Hecord	law req as beer 2 shou	ompleted	CAD							24a. Was		24b. Were au	topsy lindings available
	sician: The law certificate has b rector, page 2 s	mo	DVD						Variation and Security		osy rmed? 2 12 No	death?	completion of cause of
Vital	sian: artifica ctor, p	BeC	25. Was case referred to medical examiner?		/				ce of Death	(Check only o	one)		
0	Physician: this certific ral director,	ဥ	1 ☐ Yes 2 ☑ No	1		ER/Outpatier	IL 3 DOA					Other (Spec	cify)
	19 Je 19	Certification:	27. Manneyof Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigate		h, Day Year)	28b. Time of Injury	N W	ork? □ Yes 2		l8d. Describe I	now injury	occurred	
UIVISION	ol or Attanding after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could not lead to determine	28e. Place	of Injury - At h	ome, larm, str	eet, lactory, offic	е	2	181. Location (S	Street and	d Number or Ru	ral Route Number,
5	spitel or ours afte neral Dir filled in	Cert	4 Tromodo	Dullow	ig, etc. (opecin					Ony or To	Wii, Otalo)		
	24 h Fun etely	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the miner: On the ba and manr	isis ol examina	owledge, death ation and/or in	h occurred at the vestigation, in my	time, date a y opinion, de	and place, a eath occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the compl		29b. Signature and title of certifier	A	7		29c. Lice	nse number	. 1		29d. Date	signed (Mont)	h, Dey, Year)
	2/		Mamen 1	14			D.	3)24	7		Ja	nuary	20,2004
	V		30. Name and address of person who	completed caus	e ol death (Iter	n 23a) (Type,	Print)	BRSE	AME	548	ATE	LI MIA	), ))
	Sta	ate	30. Name and address of person who 3525 GREENWAY  31. Date liled (Month, Day, Year)  JAN 22 2	32. R	egistrar's Signa	## 20 /			1026	-11		,	
	* Registi	rar	JAN 222	004	Epsera	B	sport	2					

000 1285

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainton as scales.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1.14.04

Landover Rd. Chevery MD 20785

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If itam 27 is marked other then "natural; or ita ury or other traumatic event, the Modical Examina Baltimore, Maryland 21215-0036 Depertment of H Important: If its any injury or ot once. **Physician** /Medical

Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

na 23a or 28a-f show

Director

Funeral

þ

Completed

Be

death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurral-transit Physiclan/Medical To Be Completed by Certification

Division of Vital Records, P.O. Box 68760,

`4 □ Donation 5 □ Other (Speci	fy)	. PINCOIN CEN	hetery 1-17	-2004 bre	ii Lwood,	riD.
21. Signature of Funeral Service Lice	nsee		ddress of Facility Be Crain Highw	eall Funera eay Bowie,		715
23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the dea	th. Do not enter the mode of	f dying, such as cardiac c	or respiratory arrest,	[	Approximate Interval Between Onset and Death
tmmediate Cause (Final disease or condition resulting in death)	a. Multiorgan					Oliser and Death
	Due to (or as a consec Lung Cancer	, , , , , , , , , , , , , , , , , , , ,				
Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):				
cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic obs	tructive lung	g disease			
resulting in death) Last	Due to (or as a consec	quence of):				
•	Chronic lym	phocytic leuk	cemia			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic pregr			23d. Date of deli Month	ivery Day Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying caus	se given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Hypertensive ca	rdiovascular d	isease		1 ☐ Yes 2	□No 3□Pr	obably 4 Unknown
				24a. Was an autopsy performed?.	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?				(Check only one)		
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing Hor	me 5 Residence	6 □Other (Spec	cify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of lnjury M		28d. Describe how inju		

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hassan. A. MOLAVI. MD

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

29b. Signature and title of certifier

investigation 6 Could not be

6005

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For Stata Registrar	State o	f Maryla	and / Depa <i>Cei</i>	artment of H rtificate of L	ealth and Death	d Mental Hyg	jiene2 (	0	039	909
			1. Decedent's Name (First, Middle, Last,						2. Date of Dea Month	Dav	Year	3. Time of	
	Physicia /Medic	al	Fred Mathis						1	11'	04	13:16	РМ
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		eath		y of Death		
			Washington Advent		spital	- to a de friedfrate (a)	Takoma If Under 1 Year		Irs. 8. Date of Birth		gomer	y place (State o	r Coreign
	Funeral			t 2M 2□F	67	rs. last birthday) Yrs.	Months Days		in. July 7.	Year) 1936	Cou	esvill	
	Director		023-28-9879 Usual Residence of Decedent						July 7,	1930			
	land ow		10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside Ci	•
	Mary Fed	to	D.C.		_   '	Washing	ton			7		1 🔼 Yes	2 🗌 No
	r 288	Director	10e. Street and Number		1		10f. Zip Code			l0g. Citizen of	What Cou	intry?	
	h wit		3900 16th. Street	N.W.	<b>#512</b>		20011			US.	A		
	deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		ce - Ameri	ican Indian, , etc.	
ဖွ	or Its	교	1 Never Married 2 Married	1 ☐ Yes If Yes, Gir	2₽No ve	1	1 ☐ Yes 2 🛣 No	Specify:		Speci	ty: Bla	ack	
2-0036	within 72 hours after death with the Maryland ene. than "natural", or tlama 23e or 28a-f show than "bedical Evacifier must be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:	100 Deep	death Havel Ossue	ation		16b. Kind of E	Queinoss/Ir	dustor	
2	nati	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	TOD. KING OF E	) USI(1653/II	idustry	
2121	withir ane. than	Ĕ	Elementary/Secondary (0-12)	College (			cator	,		D.C. P	ublic	Schoo	ls
N	iled Lygi Ither nt, 1	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,				
Maryland	d be ental kad c	To Be	Edward Mathis					Bern	ice Bush				
کّ	2 should be t and Mental I is marked of raumatic eve	-	19a. Informant's Name/Relationship (T)	pe, Print)		19b. Maili	ng Address (Street	and Number of	r Rural Route Numbe	r, City or Town	, State, Zi	p Code)	5
	D = V =		Milton Harris Cou	sin		10000	Gate Par	kway No	o. #525 Ja	cksonv	ille,	FL. 3	2246
ē,	of Health item 27 other tr		20a. Method of Disposition		200	o. Place of Dispo cemetery, crea	osition (Name of matory or other place	e)	Date	20c. Location	•		
Ĕ	Page nent c int: If		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		G	reen Mo				Barnesv			
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 2005.		21. Signature of Funeral Service Licens	ion.		4	2. Name and Addres	ss of Facility ]	Marshall's W. Washing	Funer gton, D	.C. 2	ome 20011	
			23a. Par Ent the disease, or comp									Approximat Interval Bet	6 W880
В	Pnysician		shock, or heart failure. List only o Immediate Cause (Final	ne cause	cilna	nnar	On	00/1	Sna			Onset and	
	/Medical		disease or condition resulting in death)	a. Du to	(or as e cons	sequence of y.							
	Examiner		Convention list conditions	b									
	7 -	je l	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	sequence of):					1		
	nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	/	sequence of):							
8760,	cate be executed oblysician and the burial-transit		1030th ig in douth) case	000 10	(or as a cons	sequence or).							
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dlcal		d									
9 X	w requires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE:	23c. If yes, ou	tcome of pre	gnancy				23d. D	ate of deliv	very	
Вох	atten atten for u	clan	23b. Was decedent pregnant in the past 12 months?		oirth 2 ☐ F nant at time o		Ectopic pregnancy Other (specify)	<u> </u>			lonth		Year
P.O.	the d y the iched	lskı	1 Yes 2 No 9 Unknown	9□ Unkr	iown								
	s that ned b		Part II. Other significant conditions co	ntributing to c	leath but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use co	ot etudintr	. /	•
Vital Records,	quire on sig uld b	Completed by	Hanneed	uc	Vir	40 1	mmu	<u> </u>	<u>(</u> (1-1-1)	es 2□No	3 ☐ Pro	bably 4	Unknown
000	s bee	plet	Eclency	54	ndr	2ml	DIA	bet	24a. Was autop	an 24b	. Were aut	opsy findings ompletion of c	available ause of
æ	The lav	E	malitie	ha!	alm	ten9	INN'		perfor 1 ☐ Yes	med? 200 No	death? 1 ☐ Yes	290 No	
ital	ian: rtifica	Bec	25. Was case relerred to medical examiner?	01	7			26. Place of	Death Check only or	1		/	
<u>~</u>	Physician: this certific ral director,	2	1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie		4 🔲 Nursir	ng Home 5 Resid			ify)	
n of	ng P		27. Manher of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year	28b. Time of Injury	Wor		28d. Describe h	ow injury occu	irrea		
sio	Attending or death.  ctor: Atterby the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	OO - Plan	- of tokung A	t home larm et	M 1 []	Yes 2 □No	28I. Location (S	Street and Num	ther or Ru	ral Boute Nur	her
Division	s after or all Direct	Certification:	4 Homicide determined	build	ling, etc. (Spe	ecify)	lest, factory, office		City or Tow	m, State)			
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	ledical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	iner: On the I	e best of my pasis of examiner stated.	knowledge, dea ination and/or in	th occurred at the tir exestigation, in my o	ne, date and p pinion, death o	lace, and due to the o occurred at the time, o	cause(s) and n date and place	nanner as , and due	stated. to the cause(s	5)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	110	e _		29c. Licens	e number	071	29d. Date sign	ed (Month	Day, Year)	
· . I	(n)		30. Name and address of person who d	completed cau	ise of death (	Item 23a) (Type	Print)	eshin	Edon	Adin	. 14	200	
	St	ate	31. Date filed (Month, Da), Year)	32.	Registrar's Si	ignature	~	1 / MA	7 100	TIOV	1/	- p	
	Regist	rar	JAN 2 3 2004	Block	w A	Appea	w						

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ŏ Itams 23a

ŏ

'natural'

than

Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

permit. Page Department of Important: If any injury or once.

the Medical

Examiner must be notified at

Director

Funeral

Completed by

Be

2

Examine

þ

Completed

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

lasha

Manyland

the

death

within 72 hours after

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 4 Registrar 1 1 tems 23a,27 per ME,G828,02/13/0/dhbicate of Death Reg. No. 03910 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 24, 2226 P 2004 Robert Eugene McClain 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) MM 2DF 578-92-5703 38 5/21/65 N. Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Ves 2 □ No Md. P.G. Forestville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7529 Val Lane 20747 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private Industry 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert McClain Bertha Broadie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7529 Val Lane, Forestville, M1 20747 of Disposition (Name of 200. Location City or Town, State Elaine A. McClain/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 1/31/04 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 23a. Part1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20019 projumate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diabetic Ketoacidosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ✓ es 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 3XDOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Physician /Medical **Examiner** The law requires that the death certificate be executed and Box 68760. attending physician esn ò P.O. the detached Division of Vital Records. 99 been sig page 2 certificate Hospital or Attending Physician: this After death. after death Director: filled in by within 24 hours a

State Registrar

31. Date filed (Month, Day, Year) JAN 2 9 2004

29b. Signature and title of certifie

M.D Civeenberr 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

NLD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JANUARY 25, 2004

			1 - For State Registrer	State of Maryla	nd / Depa	artmen		alth and I	Mental Hyg		-	03911
ì	Physici		1. Decedent's Name (First, Middle, Last) Minhthuy Nguyer	1					2. Date of Dea Month	Day	Yeer 2004	3. Time of Death 9:10 P <sub>M</sub>
)	/Medic Examir		4a. Fecility Name (If not institution, give s Shady Grove Adve		a1		Town, or Lo	cation of Death		4c. (	County of Death	
	Funeral Director		360-46-6299	N 077 F	s. last birthday) +2 Yrs.	If Under Months		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day Oct. 28	Year) 19	9. Bint Con V16	nplece (State or Foreign untry) et Nam
	Maryland f ehow	ior	Usual Residence of Decedent  10a. State  10b. County  Maryland Montgome		City, Town or Lo		g					10d. Inside City Limits 1 □ Yes 2X No
	3a or 28a	if Director	10e. Street and Number 20034 Mattingly	-		10f. Zip		)		10g. Citiz	en of What Cou	
036	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Items 23a or 28a-f ehow event, the Medical Exam est must be indiffed at	by Funeral	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedif Yes, spec	37	nic Origin? (S Mexican, Puert	pecify Yes or No- o Rican, etc.)		4. Race - Amer Black, White Specify: As	rican Indian, o, etc. sian
215-0	within 72 ho ene. then "natur in Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupation rk done durin se retired)	n ng most of wor	king	16b. Kin	d of Business/I	ndustry
Maryland 21215-0036	uld be filed wi Aental Hygien rked other th tic event, the	Be	16+ 17. Father's Name (First, Middle, Last) Phu Tran			homem		. Mother's Nan	ne (First, Middle,	Maiden S	own ho	ome
	permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked, any injury og other traumatic ev once.	To	19a. Informant's Name/Relationship (Type Long K. Nguyen /			_			ral Route Number ce, Gait			
Baltimore,	Pages 1 ament of He ant: If item		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Ri 1 4 ☐ Donation 5 ☐ Other (Specify)	BINOVALITORI STATE	Place of Dispo cemetery, cred te of H			1-24	Date -2004		eation - City or T	
Ball	Departi Departi Importi any inji		21. Signature of Funeral Service License	aly 10^	0 1	1800	New Ha	ampshir	e Ave.,	Silv		Home, Inc. ing, MD20904
	Physician /Medical Examiner		23a. Pan1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the delete access on each line.  Metasta  Due to (or as a conse	Ltic			uch as cardiac	or respiratory arr	est,		Approximate Interval Batween Onset and Death Months
8760,	icate be executed physicien and s the buriat-fransit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse								
O. Box 68	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of preging 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pr				23	3d. Date of delive	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying c	ause given ir	Part I.	T .	acco us	,	the cause of death?
II Kecords,		Completed							24a. Was a autops perform	ned?	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
r Vital	ysicien: Th iis certilicate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No H.	ospital:atient 2[	☐ ER/Outpatien	ıt 3 🗆 DO	04		th <i>(Check only on</i>	-	Other (Speci	ify)
ion of	inding Phath. r: After the tuneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. injury at Work?	2 🗆 No	28d. Describe ho			,
Division	To the Hospital or Attending Physicien: within 24 hours after death and the Funder Director. After this certifical completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory	, office		28f. Location (St City or Town		Number or Run	al Route Number,
	ne Hospl 24 hou ne Funer letely fill	Medical	29a Certifier 1 Certifying Physics (Check only one)	ician: To the best of my kr er: On the basis of examinand manner stated.	lcwladge, deall lation and/or in	vestigation,	at the lines, d in my opinio	late and place, on, death occur	and due to the cred at the time, d	ausa(s) a ate and p	and manner as solace, and due t	stated. to the cause(s)
,	To the within to the comp	Me	29b. Signature and title of certifier  Alicia	1. Mistry	- MI		License nu		4		signed (Month,	
			30. Name and Adress of person who con Alicia Mist	mpleted cause of death lite	om 23a) (Typo, Medi (	Print)	cente	2 Dri	re Rod	ewil	le, Mr	20,2004
*	Sta Registr		31. Date filed (Month, Day, Year) JAN 23 20	32. Registrar's Sign	nature &	de	racks	/				

		1 = For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of H	ealth a Death	nd M	lental I	Hygie Reg.		0	03912
		1. Decedent's Name (First, Middle,	.ast)							2. Date o		Davi	V.I.I.	3. Time of Death
Physici		Helen M. 1	Vewman							Janua	ary 2	$20^{\circ}, 20^{\circ}$	) 04	8:32 ам
/Medic Examir		4e. Facility Name (If not institution, g	ive street and n	u <i>mber)</i>		4b. City, T	Town, or	Location of	Death			4c. County	of Deeth	1
		Montgomery Gen	eral Ho	spital		О	1ney	7				Mon	tgome	ry
Funeral			Sex	7. Age (In yrs.	last birthdey)	If Under	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date o (Month	f Birth	aarl	9. Birthp	plece (Stete or Foreign
Director		117-26-5760	1 ☐ M 2 🖾 F	69	Yrs.	MORE	Days	Hours	WHEE.	Aug.	27,	1934		ecticut
D.		Usual Residence of Decedent												
rylar thow	_	10a. State 10b. County		10c. C	ty, Town or Lo	cation							1	Od. Inside City Limits
9 Mg	cto	Maryland Montg	omery		lney									1 Tes 2 No
다 다 6 2 2	Director	10e. Street and Number				10f. Zip (					10g.	Citizen of \	What Cour	ntry?
be filed within 72 hours after death with the Maryland stal Hyglene. Ided there than "natural", or Itams 23a or 28a-1 show avent, the Medical Examiner must be positived at	al	5020 Tothill Dr	ive				2083					US		
r dez	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U Forces?	J.S. 13.	Was Decede	ent of His	spanic Orig n, Mexican,	in? (Spe Puerto	ecify Yes o Rican, etc.	r No-		e - Americ ck, White,	ean Indian, etc.
or li	by Fu	1 Never Married 2 Married	If Yes, G			1 ☐ Yes 2	. No	Specify:				Specif	Whit	e
ural'		3 Widowed 4 Divorced	Year or	Dates:	1 10 -						1			
nat	Completed	15. Decedent's (Specify only highest	Education grade com <i>pleted</i>	0	(Give	dent's Usual kind of work DO NOT use	k done d	uring most	of work	ing	161	b. Kind of B	usiness/In	dustry
han in within	E D	Elementary/Secondary (0-12)	College	(1-4or 5+)		nputer			_		Go	ddard	Space	Flight Cente
e filed within 72 hours after al Hygiene. other then "netural", or Ita vent, the Medical Exemine		17. Father's Name (First, Middle, La	et)	4	COL	nputer	. 1112			/First Mi		den Suman		Tight Cente
ild be fi fental H rked ot ilc aver	Be											den Suman	10)	
should by and Menta	မ	James P								a Mul				
permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic as once.	1 3	19a. Informant's Name/Relationship		_	1	ng Address							State, Zip	Code)
l and lealth im 27		Phillip A. Newma	n/ Husb		5020 Place of Dispo	Tothi		rive,	01:	ney,			Oite on To	Chat-
ges t of t if Ita		1 ☑ Burial 2 ☐ Cremation 3	☐Removal from	1	cemetery, crer	natory or oth	her place	<sup>9)</sup>	anu	ary 23	3	. Location -	City or 10	wn, State
Part:		*4 □Donation 5 □ Other (Spe		A1	1 Souls		,		200					Maryland
epari epari npor ny in nce.		21. Signature of Funeral Service Lic	ensee	0	F1	Name and	Addres	s of Facility	lns	Funer	al H	ome I	nc.	
205 2 9		xans "		Dley	]50	00 Uni	vers	sity E	31vd	. W,	Silv	er Sp	ring,	MD 20901
		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that by one cause on	caused the lee	th. Do not ent	er the mode	of dying	g, such as c	ardiac	or respirato	ry arrest,			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Aort	ic Rupt	ure								ŀ	Onset and Death
/Medical		resulting in death)	a	o (or as a conse										
Examiner														
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to	o (or as a consec	quence of):									
cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events	С.											
an ar	EX	resulting in death) Last	Due to	o (or as a consec	quence of):									
ysici	cai	· ·	d											
tifica ng ph as th	fedi													
that the death certifi ed by the attending I detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 □ Feta		Ectopic pre	ananov					23d. Da	te of delive	ery
deat e att	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Preg	gnant at time of		Other (spe					_	Мо	nth	Day Year
t the by th	hys	9 Unknown	9□ Unk	nown										
requires that een signed b nould be deta	by P	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying ca	iuse give	n in Part I.		23e. [	oid tobac	co use cont	ribute to th	ne cause of death?
quire n sig uld b										1	Yes Yes	2 □ No	3 Prob	ably 4 Unknown
> 0 7	Completed									24a. V	Vas an	24b. \	Were auto	psy findings available
0 = 0	E C								_	P	utopsy eriomed	1?   0	death?	npletion of cause of
ician: Th certificate rector, pag	Ö	25. Was case referred to medical						OC Place	- ( D + )		es 2 🔯	No 1	Yes	2 LI No
	o Be	examiner?  1 Yes 2 XNo	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DO/	Othe	26. Place				e 6 □Oth	na /C 1	
Phys r this ral di	H	27. Manner of Death	-	e of Injury	28b. Time of		Bc. Injury					njury occurr		"
ding h. Afte fune	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Mo	nth, Day Year)	Injury	м	Work	.? ∕es 2 ∐ N				,,		
deal deal ctor	fica	3 ☐ Suicide 6 ☐ Could no	be age Blee	ce of fnjury - At h	ome, farm, str	eet, factory.				28f. Locatio	on (Stree	t and Numb	er or Rura	I Route Number,
To the Hospital or Attending Pi within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	ertification:	4 ☐ Homicide determine		ding, etc. (Speci							Town, S			
apita ours naral filled	0	29a. Certifier 1X Certifying	Physician: To #	ne best of my kn	owiedge death	n occurred a	it the tim	e date and	place	and due to	the caus	e(s) and ma	nner as at	ated
24 h Fur stely	edical	(Check only 2 Medical Ex	aminer: On the	basis of examination	ation and/or in	vestigation,	in my op	inion, death	occurr	ed at the ti	me, date	and place,	and due to	the cause(s)
o the	Me	29b. Signature and title of certifier	. //			29c.	License	number			29d.	Date signed	d (Month. i	Dey, Year)
F 3 F 8		1/1/2	11	_			D053							
12		1 Collection			- 00.1 =			,ou <del>4</del>			J	anuary	y 21,	2004
		30. Name and address of person wh						#100		1	MD	20822		
		Richard A. Silv  31. Date filed (Month, Day, Year)		09 Prin		Lip Dr	ive,	# IUU	, 0.	rney,	LID .	20032		
Sta	ate rar	IAN 2.2	004	Preserva	14	100	معمل م	1						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month January Walter Francis Neary 15, 2004 5:45 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 043-07-1284 Director 15, 1906 Oct. Connecticut Usuel Residence of Decedent filed within 72 hours aftar death with the Merylend 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits **ehow** y 28a-f show 1⊠Yes 2□No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 303 Adclare Road 20850 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ŏ Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ② No Specify: Specify: White <u>چ</u> 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health end Mentel Hygiene. int: If Itam 27 is marked other then " Iry or other traumatic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) 12 Programs Officer U.S. Department of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Neary Jane McNamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 17812 Hidden Garden Lane, Ashton, MD 20861 Judith A. Mahachek/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 19 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, MD Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd. W., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia 20 days Examiner Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and I for usa as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Due to (or as a consequence of): signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Congestive Heart Failure cartificate has been si iractor, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Myocardial Infarction T□ Yus 2⊠No 1 ☐ Yes 2 ☐ No To the Hoepital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this cartifica complataly filled in by the funeral director; 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) wo January 16, 2004 D58681 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Jude Alexander 1201 Seven Locks Road, #111, Rockville, MD 20854 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 0 2004

DHMH 16 Rev 6/95

Registrar

			•
State of Maryland	Department of	f Health and	Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** January 13, 2004 Josephine Natoli 9:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Millennium Health and Rehabilitation Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Day, Year) June 13, 1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🛛 F Months Tealy 96 Yrs Director 578-80-1752 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than \*natural", or items 23s or 28s-f show the Medical Examiner must be notified at D.C. None 1 No 2 No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2223 38th Street, NW Funeral 20007 filed within 72 hours after death USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: 3 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Valenti Anthony Padua 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose A. Pizzola/Daughter 2223 38th St., NW., Washin ton, DC 20007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan.16. 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2004 Brentwood, Maryland 22. Name and Address of Facility De Vol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 21. Signature of Funeral Service Vicensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Failure Examiner Due to (or as a consequence of). Examiner Congestive Heart Failure signed by the attending physiclan and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Hypertension Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): Aortic Stenosis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Dementia þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? peen : has 1L Yes 2X No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this Il Director: After this ed in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Af 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled edical 29a Certifie X Conflying Physician: Thithe best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D00-51520 January15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave., S.E. #310 Wash., D.C. 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks JAN 2 0 2004 Registrar

			For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artmen tificat	t of H e of L	ealth a Death	and M		iene eg. No.	2004	03915	
	Dhunini		1. Decedent's Name (First, Middle, Last	)			2.7				2. Date of Dear Month 01/16/		, Year	3. Time of Death	
	Physici /Medic	al -	Dorothy		Α.			rris -			01/16/			5:52 P M	
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,		Location of	of Death			County of Death Prince G		
			Southern Maryland 5. Social Security Number 6. Se	Hospital	Cent	er ast birthday)	If Under	1 Year	nton If Under		8. Date of Birth		9. Birth	place (State or Foreign	
	Funeral Director			_M 2₹_X	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birth	923	Wash	Migton, DC	
	P .		Usual Residence of Decedent		100 City	, Town or Lo	anting							10d. Inside City Limits	
	show	5	10a. State 10b. County		TOC. City	Suitl							1 ☐ Yes 2 Ã No		
	the M	Director	Maryland Prince G	eorge s		Surtr	10f. Zip	Code			1	0a. Citi	Citizen of What Country?		
	With With	直	6023 Lucente Aven	ue				207	46			Ţ	ŕ		
	death ms 23	era	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S	S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White		
ထ္	or Ite	E.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X☐XI If Yes, Give	No	i	1 ☐ Yes		Specify:	1, 1 46110	riouri, oto.,		-	hite	
8	hours after death with the Maryland turel', or Items 23a or 28e-f show at Examinat must be rigitlised at	Completed by Funeral	3K□XWidowed 4 □ Divorced	Year or Dates:	1							10h K		adusta.	
5	n 72 h	jete	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Dece (Give life.	kind of wo DO NOT us	rk done d se retired	ation during mos. ()	t of work	ing	IOD, KI	nd of Business/Ir	idustry	
12	I within ienė. r than "	щo	Elementary/Secondary (0-12)	College (1-4or 5	(+)		Homem						In H	Iome	
ğ	be itled within 72 hours after death with the Marylan ital Hygiene. Ind other than "neturel; or Items 23a or 28e-f show other than "neturel; or Items 23a or 28e-f show event, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)	_					18. Mothe		e (First, Middle,				
/lar	ould be Mental arked o	10	Joseph Sichert	Sr.							abell 		UNKNOWN		
Maryland 21215-0036	2 sh and and Is m		19a. Informant's Name/Relationship (7			I	•				al Route Number				
	lan Heal		Josephine Simmo	ns / Exec		ace of Dispo		- 100	h Dri		Oxon Hil		Mary Land cation - City or T		
Ž	ages in of h		1 ⊠ Burial 2 ☐ Cremation 3 ☐			motory cros	matoni or o	ther plac	eterv					Maryland	
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		* 4 ☐ Donation	-							. Kalas				
Ba	Departiment of the permit of t		Jeuf Va	luh			6160	0xon	Hill	ge r. L. Roa	ad Oxon	Hil.	erai nom 1. Marvl	and 20745	
			23a. Part. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	one says on sagn in	5	SEPTI	C SH	OCK					4	Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequ	ience of):	CEMI	. ^						, i	
	Examiner		Sequentially list conditions,	b			CEMI	. A.							
	ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience or):									
	ate be executed obysician and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):									
8760,	siciar buria			d											
9	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical										1			
Вох	eath certifica attending ph I for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			∃Ectopic p	regnancy					23d. Date of delive	very Day Year	
	e dea the att	Sici	in the past 12 months? 1 □ Yes 2 <b>2</b> □No 9 □ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5	Other (sp	pecify)					Monar	22,	
P.0	that the dened by the detached		Part II. Other significant conditions of	ontribution to death h	ut not resu	ulting in the u	inderlying o	ause div	en in Part I	I.	23e. Did to	bacco u	ise contribute to	the cause of death?	
ds,	ires that signed I d be det	by	Tak II. Other signmeant conductions	oranouting to dodd to	0111011000	and a second		acco g	J., ,		1 □ Y	es 2	□No 3□Pro	bably 4∑Unknown	
of Vital Records,	w require been sign	Completed									24a, Was a		24b. Were aut	opsy findings available	
Rec	The law ate has page 2 :	E C									autop: perfor	sy med?	prior to co	ompletion of cause of	
tal		ပိ	25. Was case referred to medical						26. Place	e of Deat	1 ☐ Yes h (Check only or	2 <b>X</b> No ne)	TL: Yes	2[_] NO	
>	Physician: r this certificatal director, I	To B	examiner? 1 ☐ Yes 2⁄(X)%	Hospital: 1 🛮 Inpatie	ent 2 □ I	ER/Outpatie	nt 3 D0	Oth Oth	or:		ome 5 Resid		6 □Other (Spec	ify)	
٥	ding Phys I. After this funeral dia		27. Manner of Death  1x1  1x2  1x2  1x2  1x2  1x2  1x2  1x	28a. Date of Inju (Month, Da	y Year)	28b. Time o	of 2	28c. Injun Wor	y at k?		28d. Describe h	ow injur	y occurred		
Sio	Attending or death. sector: After by the fune	catic	2 ☐ Accident investigation				М		Yes 2□	No			=		
Division	l or Atteno after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, st /)	reet, factor	y, office			28f. Location (S City or Tow	treet an n, State	d Number or Rui	ral Route Number,	
	ospitel or A hours after unerel Dire ly filled in by		29a. Certifier	ysicien: To the best	of my know	wledne deal	h occurred	at the tin	ne date ar	nd place	and due to the o	ause(s)	and manner as	stated.	
	24 ho 24 ho e Fun etely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner st	f examinat	tion and/or in	vestigation	i, in my o	pinion, dea	ath occur	red at the time, o	late and	d place, and due	to the cause(s)	
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	A ^			29		e number	707	2		te signed (Month		
			11/25	-149				יע	JU42.	, 0 /		C	1 - 17 - 2	004	
2	(12)		30. Name and address of peren who					#601	L (°1 ; .	ntor	, Maryla	n d	20735		
	U		George B. Fren	40.0-1-1-1	la Ciana	yard R		# 00 ]		OII	, raryta	11111			
	St Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signa	bo	The same								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15 2004 January 2:00 A M **Physician** Dale Kenneth Nonnemacher /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 2522 Knighthill Lane Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 100 M 2□ F 8,1931 Pennsylvania 218-28-0997 72 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hyglene.
and if Health and Mental Hyglene.
and if it is not 72 is marked other than "natural", or itema 23a or 28a-1 show ury or other traumatic event, the Marylan Example of the molities. 1 XYes 2 No Prince George's Bowie Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 2522 Knighthill Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1951-55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 💆 Married 1 ☐ Yes 2 X No Specify: White Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public School Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Margaret Unangst Freeman Nonnemacher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, MD. 20715 2522 Knighthill Lane Elizabeth A. Nonnemacher/spouse Baltimore, 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 1-21-2004 Cheltenham, MD. MD. Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall FuneralHome 21. Signature of Funeral Service Licensee 20715 6512 NW Crain Highway Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Intervat Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) l year Hepatocellular carcinoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the r use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part tt, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 med? 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To ths Funeral Director: A investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 16, 2004 D53829 no completed cause of de th (ttem 23a) (Type, Print) address of person Greenbelt, MD. 20770 7525 Greenway Center Dr. Kevin J. Shannon, M.D. 2. Registrar's Signature 31. Date fited (Month, Day, Year) State JAN 2 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 0 3 9 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 20 ANNIE BELL NOBLE JANUARY 2004 11:21P 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SOUTHERN MARYLAND HOSPITAL CENTER CLINTON
If Under 1 Year | If Under 24 Hrs. PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 □ M 200 F 226 09 3646 98 OCT. 05, 1905 MILTON. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5710 BUTTERFIELD DRIVE 20735 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Yes XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married XX No 1 ☐ Yes XX No Specify: Specify: BLACK Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5TH FACTORY WORKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN MARTHA MITCHELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS NOBLE / GRAND DAUGHTER 5710 BUTTERFIELD DRIVE CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State \* 4 □ Døñation 5 □ Other (Specify) LINCOLN CEMETERY 01/26/2004 SUITLAND, MD 21. Signature of Funeral Service Licensee MARSHALL S FUNERALHOME OF MARYLAND, INC. 6/ 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Pant1. Ehler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, diffheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ommuni Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown insufficiency 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ Vo 24a. Was an 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

al Hygiene.

12 should be find and Mental H

Peges 1

item 27

ö Department Important: If any injury or once.

Maryland 21215-0036

Baltimore,

68760,

Box (

o

م

Vital Records,

Division of

2

Completed

Be

been certificate this Aller

Physician/Medical ş Completed tuneral director, Be Certification: To or Attendinate after death. Medical

To the Hospital within 24 hours a To the Funeral C

State Registrar

31. Date filed (Month, Day, Year) JAN 2 2 2004

5 Pending investigation

6 ☐ Could not be

1 Carumau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27. Manner of Death

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifie

29a. Certifier

RAHIMIAN MD Registrar's Signature

MD

28a. Date of Injury (Month, Day Year)

7501 SURRATTS ROAD 205 CLINTON MD20735

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3□ DOA

28c. Injury at Work?

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Tyes 2 TNo

DO052994

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dev. Year)

21/2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 9:45 A M **Physician** 17 2004 OUNNIE NELSON 1 /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S 12209 WESTMONT LANE BOWIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 3 22 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. 1 ☐ M 2X F 75 Yrs. VĬŔĠĬŊĬA 1928 230-26-6767 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural; or Items 23a or 28a-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Mudical Exame are must be notified at 1 Ty Yes 2 □ No Director PRINCE GEORGE'S BOWIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20715 12209 WESTMONT LANE Funerai 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ENVIROMENTAL SERVICE 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELEANOR F. HENDERSON WATSON JERSON REDWOOD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 WESTMONT LANE BOWIE, MARYLAND 20715 19a. Informant's Name/Relationship (Type, Print) BRENDA PRESTON/DAUGHTER or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 1-24-04 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service kicense 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial transit Hypertension and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Diabetes Mellitus IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? 1 Yes 2×2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1X Natural 5 Pending safter death. 1 Yes 2 No 2 Accident investigation completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 🖔 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier æner iscome nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ANITA CLAYTON M.D. 1011 NORTH CAPITAL STREET N.W. WASHINGTON DC 20002 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 2 3 2004 Registrar

		1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H	lealth and M Death		ene 20 (	03919
		1. Decedent's Name (First, Middle, Las	()				2. Date of Death		3. Time of Death
Physi	iciar dica	ROBERT ST.	ANLEY OAKES				Month January	Day Ye	04 3:05 P M
Exam		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Death		4c. County of I	
		Montgomery Gener	al Hospital		01nev			Montgo	mery
Funera	al	5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
Directo	or	370 20 4231	ØM 2□F 81	Yrs.			July 19		Colorado
pug *		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
faryl:	2	All 22		lver Sp					1 ☐ Yes 2 No
the A	Ctograd	10e. Street and Number	nery br	TVCI OP	10f. Zip Code		10	g. Citizen of Wha	t Country?
with	Ĉ	0600 71 1				26			. County .
leeth ns 23	Financial	3632 Edelmar Terr	ace 12. Was Decedent Ever in U	J.S. 13. V	2090 Was Decedent of H	JO i <i>s</i> panic Origin? (Spe		JSA 14. Race -	American Indian,
fler d	1	1 Never Married 27 Married	Armed Forces?	1	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		White, etc.
urs a	3	3 Widowed 4 Divorced	If Yes, Give 1942 Year or Dates: 45	2 to	1 ☐ Yes 2√ No	Specify:		Specify:	White
2 ho	Completed	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occup	ation during most of worki	1	6b. Kind of Busin	ess/Industry
hin 7	9	(Specify only highest gra	College (1-4or 5+)	life. I	DO NOT use retired	during most or work. 1)			
ad will	į		4	Phot	ographer		IN.	ational	Geographic
al Hy	Be					18. Mother's Name	(First, Middle, M	aiden Surname)	
Ment Ment Ment Ment Ment	Ş					Ruth Phe	ennah		
and and series		19a. Informant's Name/Relationship (7				and Number or Rura			
and and n 27		Patricia Oakes/Wi		-					ryland 20906
partition of the parties of the parties of the parties of the parmit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatil and Mental Hygiene. Inmopriant: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examination in this martified at	1	20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐		Place of Dispo cemetery, cren	sition (Name of natory or other place	:e)	ate 2	0c. Location - Cit	or Town, State
Definition  Sermit. Pages Department of  mportant: If It iny injury or or	0	` 4 □ Donation 5 □ Other (Specify		tropoli	tan Crema	atory 01/2	1/2004 A	lexandri	a, Vir inia
ormit.	DUCE.	21. Signature of Funeral Service Licen	S00	22	. Name and Addres	ss of Facility ONEY & KIN	IC FINER	AT HOME	INC
205	a	Hickary O File	orulas		1	71 W. Map	le Ave.,	Vienna,	Va. 22180
		23a. Part1. Enter the disease, of comp shock, or heart failure. List only	lications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
Priysicia	an -	Immediate Cause (Final disease or condition	ANUX	11 6~	IEPHAL	UPATI-11			Onset and Death
/Medica	-	resulting in death)	Due to (or as a consec	quence of):					
Examine	<b>S</b>	Sequentially list conditions,	b						
בַּי ק	<u> </u>	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
The Coulds, F.C. BOX 80/80,  The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Fyaminar	that initiated events resulting in death) Last	C. Dun to (or on a const						
e be ex sicien	ú		Due to (or as a consec	quence or):					
cate b			d						
that the death certific ed by the attending p	Dhvelclan/Mo	IF FEMALE:	23c. If yes, outcome of pregn	anav					
ath c	100	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	al death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
hed the	200	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	death 5∟	Other (specify)				
that the			ontributing to death but not re-	sulting in the w	nderlying cause givi	an in Part I	23e. Did toba	icco use contribu	te to the cause of death?
w requires that been signed should be del	2		<b>3</b>		industry in ground and			/	Probably 4 Unknown
w require	Completed								
e law	2	-					24a. Was an autopsy perform	prior	e autopsy findings available to completion of cause of
The The Cate	3						1 ☐ Yes 2	3No 10	Yes 21 No
ician: Sertifica ector. p	a	examiner?	Hospital:		Oth	26. Place of Death			-
Phys this	F.	TO THE ZEINO	1 Inpatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of		er: 4 Nursing Hor			Specify)
Jing Jing After	5	1 Natural 5 Pending	(Month, Day Year)	Injury	Worl	Yes 2 □ No	28d. Describe hov	r injury occurred	
Attending r death. ector: After by the fune	0	2 Accident investigation 3 Suicide 6 Could not be		lome farm etc			Of Location /Stm	not and Alumbas a	r Rural Route Number.
or A affer Direction by	Certification.	4 Homicide determined	building, etc. (Speci	fy)	eet, ractory, onice	1	City or Town.		nurar noute rumber,
pitel ours eral filled	100		ysician: To the best of my kno	owledge death	accurred at the tim	ne date and place	and due to the cau	se(s) and manne	r ac etated
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Attent this certificate has completely filled in by the tuneral director. page 2:	icaipa	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my of	pinion, death occurre	ed at the time, dat	e and place, and	due to the cause(s)
o the	N				29c. License	e number	29	d. Date signed (M	Ionth, Day, Year)
1		by april m	gr. mp		02	3630	J	invery	19.2004
0		30. Name and address of person who	completed cause of death /Iter	m 23a) (Tune	Print)				
		FRANK J. MAY	' MO	6220	FREDERI	CIC RO A	213, 60.	theo, b.	-1, mn 2057)
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa		1	,	···		
Regi		JAN 2 2 20	104 Janeura	13	Sparks				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#1&3per MD1/28/04, BMW, McCo 1. Decedent's Name (First, Middle, Last) NEVA 3. Time of Death 2. Dete of Deeth IRENE PURSELL JANUARY 18, 2004 2:45 🚓 **Physician** IDENE PURCELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner ROCKVILLE NURSING HOME ROCKVILLE MONTGOMERY If Under 1 Year 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yeer) Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 🗓 F Yrs. Sept 7, 1907 Nebraska Director 96 214-48-9870 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Silver Spring Maryland Montgomery 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number Funerai 3234 Hewitt Ave, #20 20906 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Black, White, etc. 1 Never Merried 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: ۵ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Julia Christina Nickel Earl Emmett Lackey 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy P. Schulze/Daughter 764 Azalea Dr. Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Jan 22, 2004 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Fun al Service License 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Congestive Heart Failure 2 weeks **E** miner Due to (or es a consequence of): Physician/Medical Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Senile Dementia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 2.XN0 1 ☐ Yes 2 ☐ No certificate or Attending Physician To the Hospital or Attending Physician. within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification To 28b. Time of Injury 28e. Date of Injury (Month, Dey Year) Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as steted.

| Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as steted.

| Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ( M resto 20 D31839 January 21, 2004 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 615 W. Montgomery Ave, Rockville, MD 20850 C. Dunford, MD Christopher 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

State

Registrar

JAN 22

2004

			For State Registrar	State of Ma	ryland /		artmen rtificate				lental Hy	/giene	2004	03921
			1. Decedent's Name (First, Middle, Last)								2. Date of Do	eath Day	Year	3. Time of Death
	Physici /Medio	_	Do	onald Lee	Pugh						Januar	y 14,	2004	9:00 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give si	treet and number)			4b. City,	Town, or	Location of	of Death		4c. C	County of Death	
Е			Shady Grove Advent	ist Hospi	tal			ockv					ontgome	
	Funeral		5. Social Security Number 6. Sex	M 005	(In yrs. last I		If Under Months		If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birthr	olece (State or Foreign
	Director		5//-44-9258	M 207	69	Yrs.					Aug. 26	5 <b>,</b> 193	4 Mar	yland
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					- v-	1	IOd. Inside City Limits
	fanyli aho	ō			7.									1 ☐ Yes 2 ☑ No
	28a-i	ect	Maryland Montgomes  10e. Street and Number	гу		Koc	kvill					10a Citiza	en of What Cour	ntry?
	with a or	ā	13409 Crispin Way				702.5	208	5.2			-	d State	-
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ahow the Medical Evantres must be notified at	Funeral Director		2. Was Decedent E	ver in U.S.	13.	Was Deced			gin? (Spe	ecity Yes or N		4. Race - Americ	
	r Iten	Fu	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give		i				i, Puerto	ecify Yes or No Rican, etc.)		Black, White,	etc.
036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Korea		1 ☐ Yes	2₩ No	Specify:			5	Specify: Wh	ite
21215-0036	2 ho	ted	15. Decedent's Educ		16	Sa. Dece	dent's Usua kind of wo	al Occupa	ition	t of work	ina	16b. Kind	d of Business/In	dustry
21	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT US	se retired,	)	O HOIK	'ig			
	er th	Completed	12		C	abin	et Ma	ker					om Furn	iture
nd	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)								(First, Middle	e, Maiden S	Sumame)	
<u>ya</u>	Ment Ment Brke	ို	George A. Pugh						Jane	e Nic	cho1s			
Maryland	2 she and is m		19a. Informant's Name/Relationship (Typ	e, Print)			-					_	Town, State, Zip	
	and ealth m 27		Helen B. Pugh/Wife					-	-				land 20	
ore	of H if ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	20b. Place ceme				") <sup>j</sup> J	anua	ry 20,	20c. Loc	ation - City or To 7111e,M	own, State
Ë	Page Hand		* 4 ☐ Donation 5 ☐ Other (Specify)		Park1									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or items 23e or 28e-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	,	00198	Ro	Name an bert	A Addres	umph:	rey 1	Funeral	Home	Bethes Chas	da-Chevy e Inc.
			23a. Part1. Ent r the disease, or complic	ations that caused	the death. D								20814-	Approximate
8	Dhysisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line			- V-		- ( 0	ila	Ni 1.	-X -	<b>1</b>	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a			6 1	Cr	0 ~0	6 101.	ial in	761	c Clan	
gie?"	Examiner			9	1.100	C	SI	200	10					
		ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a	nonsequand	a of)		1100						
	d d ansit	Examiner	d any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	X2MF	10	C'	000	105	9/0	9	alks			
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequenc	e of):	~							
760,	ysick	cal	d	Erd	sta	30	100	2 40	13	Di	7 € 0.	10		
89	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit		ALCENIA C											
Вох	th cea endir	an/	23b. Was decedent pregnant	3c. If yes, outcome of 1□Live birth		ıth 3.∏	Ectopic pr	egnancy				23	3d. Date of delive	,
	deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t			Other (sp			· · · ·		Ì	Month	Day Year
P.O.	at the	Phy	9 Unknown											
	es th igned	Completed by Physician/Med	Part II. Other significant conditions con	-	it not resulting	g in the u	nderlying c	ause give	in in Part I.	•		\_		he cause of death?
brd	requires een sign hould be	ted	* * * * * * * * * * * * * * * * * * * *	02100							1	Yes 21	Kyo 3∏ blog	pably 4 Unknown
ec.	a a	ple	Didbeles	Rec	111/2	,					24a. Was	psy	prior to co	psy findings available mpletion of cause of
R	The ate h page	Го									perfe	órmed? 2.√No	death?	
Division of Vital Records,	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			_				of Death	(Check only			
<b>5</b>	hysic nis ce I dire	卢	1 ☐ Yes 2 No	ospital:		Outpatier			4   Nu	rsing Ho	me 5 Res	idence 6	Other (Specif	(y)
0	fte ne	 	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b	. Time of Injury	f 2	8c. Injury Work	at ?		28d. Describe	how injury	occurred	
9	Attending I er death. ector: After by the funer	atl	2 Accident investigation				М	1 🗆 Y	′es 2 🗆	No				
Ξ̈́	r Att ter d irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, str	eet, factory	, office				(Street and wn, State)	Number or Rura	il Route Number,
	ital c									1				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)  1   Certifying Phys 2   Medicel Examin	er: On the basis of	examination.	lge, deatl and/or in	h occurred vestigation	at the tim, in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a , date and p	ind manner as s place, and due to	tated. the cause(s)
	the thin 2 the mple	Med	29b. Signature and title of certifier	and manner state	100.		290	c. License	number			29d Date	signed (Month,	Day, Year)
	T vil	_	29b. Signature and title of certifier								43			
	541		4111				1	) 41	167			7 d L	1462	145004
	. ,		30. Name and address of person who con	npleted cause of de	eath (Item 23a	(Type,	Print)	CIT	141	ω (	2611	1000	2001121	142004
			31. Date filed (Month, Day, Year)		r's Signature	-	200	-1 1	211 00		11	nak	(-0(1)	9 1 7
	Sta Regist		JAN 2 0 200	-	na	9	200	rith	1					

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment of F	lealth a	and M		gien Reg. N	-40 4 40 1	03	922
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of De Month		ey 2004 ar	3. Time o	
	/Media	al	LEON PR	ESBURY			4b. City, Town, o	r Location	of Death	UAN.		c. County of Deat	2:44	. P.M
	Examin	er	Laurel Regio		.tal		Lau	-	o. Dog			RINCE (		ES
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	1	9 Riet	ontece (State	or Foreign
	Director		219-34-9767	<b>X</b> □M 2□F	67	Yrs.	Monato Days	,,,,,,,,		Sept.	27,	1936	Mary]	and
	land ow		Usuet Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	ocation						10d. Inside C	ity Limits
	Mary a-f ah	io	MD Montg	omery			Silver	Spri	ng				1 🗆 Yes	2 <b>∑</b> No
	should be filed within 72 hours atter deeth with the Maryland nd Mental Hyglene. marked other than "natural", or Items 23e or 28e-f ahow marked other than "natural", or Items 21e incillised at imatic event, Ita Madical Examilian institutional incillised at	Funeral Director	10e. Street and Number	ו דד	124		10f. Zip Code	004			10g. C	itizen of What Co	-	
	s 23a	erai	13827 Castle	12. Was Decedent		S 12		904	igin? (Spe	cify Ves or No	١.	U.S.A.		
	r Iter d	Fun	1 Never Married 2 Married	Armed Forces?			Was Decedent of H			Rican, etc.)		Black, White	e, etc.	
ğ	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ No	Specify:				Specify: Bla	ack.	
<u>5</u>	"natu	lete	15. Decedent's E (Specify only highest gi	ducation rade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	it of worki	ng	16b.	Kind of Business/I	ndustry	
7	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		uto Mec		С			Auto Se	ervice	2S
2		0	17. Father's Name (First, Middle, Las							(First, Middle		n Sumame)		
<u>ya</u>	ould b Menta arked	To	Winfield Pr	<b>_</b>						Bond				
Maryland 21215-0036	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship Brenda Presbu				ng Address (Street					or Town, States		
آ ب	Heall Heall tem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place		-	ate		_ocation - City or		
E	Pages Int. #		¹X Burial 2 ☐ Cremation 3 [  '4 ☐ Donation 5 ☐ Other (Speci			h Mem	orial C	em				ndy Spi		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked, any injury or other traumatic evones.	(	21. Signature of Funeral Service Live	nsee	1		2. Name and Addre							
17			23a. Part1. Enter the disease, or con shock, or heart failure. Ust only	nplications that caused y one cause on each lin	the death	n. Do not ent	er the mode of dyin	ng, such as	cardiac c	or respiratory a	rrest,		Approxima Interval Bel Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Sudder			Death						Onsor and	
	Examiner			Due to (or as			thmoden	ic D	eath					
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):								
<b>,</b>	te be executed ysicien and le burial-transit	Exan	that initiated events resulting in death) Last	c. Atnerd			c Heart	DIS	ease					
8760,		cai		o Possib	ole (	Coron	ary Art	ery 1	Dise	ase				
P.O. Box 68	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[	□Ectopic pregnancy □ Other (specify) _	/				23d. Date of deli Month		Year
	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions Hypertens	3		•	nderlying cause giv	en in Part I				use contribute to	the cause of o	
Ö	aw requir s been si 2 should	ojete	Diabetes	Mellitus	Тур	e 2				24a. Was		24b. Were au	topsy findings	available
m m	hysicien: The lav nis certificate has I director. page 2	Completed	Renal Ins	ufficienc	ey .						psy ormed? 2 <b>∑</b> N	death?	ompletion of d 2□ No	ause of
Vita	Attanding Physicien: r death. sctor: Atter this certifics by the funeral director.	Be	25. Was case referred to medical examiner?	Hospital:	-		Oth			(Check only				
0	<u>n</u> = a	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	I 🗀 inpatre		ER/Outpatier 28b. Time o	nt 3□ DOA Our	vat		ne 5 🗌 Resi 28d. Describe		6 □Other (Spec	ify)	_
O	nding Ph th. : Atter th s funeral	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da)	Year)	Injury	Wor	k? Yes 2□	1			.,		
Division of Vital Records,	Hospitel or Attending I 44 hours after death. Funeral Director: Atter tely filled in by the funer	Certification:	3 Suicide 6 Could not determined	28e. Place of Injuding, etc	ury - At ho c. (Specify	ome, farm, str	eet, factory, office			28f. Location ( City or To		and Number or Ru te)	ral Route Num	nber,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1☆ Certifying P  (Check only one) 2  Medical Exe	hysician: To the best eminer: On the basis of and manner sta	examinat	wledge, death tion and/or in	h occurred at the tirvestigation, in my o	me, date ar epinion, dea	nd place, a	and due to the ed at the time,	cause( date ar	s) and manner as nd place, and due	stated. to the cause(s	s)
	To the comp	ž	29b. Signature and title of certifier				29c. Licens				29d. D	ate signed (Month	, Dey, Year)	
,	4		• Kun				D005le1	15				13/04		
			30. Name and address of person who	1 Avenue	Sui	te 43	Print) G F	far.	r, M	PANIK	in	0 209	12	
	Sta Registi		JAN 22 2	004 32. Registr	ars Signa	ture &	Spork.							

			State of Maryland / De	epartment of Health and Months of Death	lental Hygie	ne 2004	0392
	<b>D</b> 1 111		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Media		Jeanne Ann Potter		January 1	L6, 2004	2:50 A.M
	Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Suburban Hospital	Bethesda		Montgomer	
*	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthe	Months Days Hours Min	8. Date of Birth (Month, Day, You Jan. 30,	9. Birthp Coun 1930 Virg	lace (State or Foreigr try) inia
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location		1	Od. Inside City Limits
	ath with the Marylar 123a or 28a-f ahow assi be recilled at	Director	Maryland Montgomery Bethe				1 ☐ Yes 2 📉 No
	with	급	9820 Parkwood Drive	10f. Zip Code 20814		Citizen of What Coun	•
	death ma 20	Funeral		13. Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	
920	urs after deal at', or itama	by	1 ☐ Never Married 2 ☑ Married  1 ☐ Never Married 2 ☑ Married  1 ☐ Yes 2 ☑ No  1 ☐ Yes 3 ☑ Widowed 4 ☐ Divorced  Year or Dates:	ff Yes, specify Cuban, Mexican, Puérto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Bfack, White, Specify: Whit	etc.
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, Item 27 is marked other than "natural", or itema 23s or 28s-1 ahow other traumatic avant, the Medical Executed Exercise Exercised at	Completed	15. Decedent's Education (Specify only highest grade completed)  Efementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired)	ing 160	. Kind of Business/Inc	dustry
21	ed wit	Con	4 H	omemaker	(	Own Home	
land	Ald be file Mental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) William L. Phalen	18. Mother's Name Reba Lou	e (First, Middle, Mai 1gh	den Sumame)	
lary	and A	-	19a. Informant's Name/Relationship (Type, Print) 19b. N	failing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zip	Code)
Σ	and 2 ealth n 27			O Parkwood Drive, B	ethesda,	Maryland 2	0814
ore	T ite		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 20b. Place of D MONLE OI	and the state of t	oate 200 ry 18,	c. Location - City or To	wn, State
Ë	tant:		'4 Donation 5 Other (Specify) Crema	torium, Inc 20	04 Be	ethesda, Ma	
Bal	permit. Pages 1 Department of I- Important: If ite any injury or of once.		21. Signature of Funeral Service Micensee  M01353	<sup>22.</sup> Name and Address of Facility Rob Bethesda-Chevy Chase Bethesda, Maryland	ert A. Pu 1nc. 7 20814	mphrey Fun 57Wiscons	eral Home in Avenue
m	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Seizure disorder resulting in death)		or respiratory arrest.		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)				I week
B	Examiner *	_	Sequentially list conditions, b.				
	ed isit	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
	ate be executed hysicien and he burial-transit	хап	that initiated events c. Due to (or as a consequence of)				
760,	te be e ysicier	cal	<b>L</b> <sub>d</sub> ,				
89	ificate g phy as the		U				
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
0	t the by the	hys	9 Unknown				
ਜ਼ੂਅ Records, P.O.	quires than signed I	P	Part II. Other significant conditions contributing to death but not resulting in the Pare TWO TWO YAX	ne underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	couse contribute to th 2 ☑ No 3 ☐ Proba	e cause of death?
<b>S</b> S	s been si	Completed	Clostrium difficile colitis		24a. Was an	24b. Were autor	osy findings available
R.	The la	шо	Charles contis		autopsy	death?	osy findings available appletion of cause of
Vital	ien: rtifica	BeC	25. Was case referred to medical	26. Place of Death	1 Yes 2 ☑ (Check only one)	No 1 ☐ Yes	2 LI NO
જ <b>&gt;</b>	nysic ans ce	70 E	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpi	Other		e 6 □Other (Specify	)
vision of	ng Pl		27. Manner of Death 28a. Date of Injury 28b. Tim 1 ☑Natural 5 ☐ Pending (Month, Day Yeer) Inju	ne of 28c. Injury at	28d. Describe how i		
5.5 Sign	Attanding Physician: r death. sctor: After this certification of the funeral director.	catt	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
O V	tal or At rs after d al Direct ed in by	Certification:	4 Homicide determined 288. Place of Injury - At nome, farm building, etc. (Specify)		City or Town, S		
-	To the Hospital or Attanding Physicien: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, companies on the basis of examination and/companies and manner stated.	leath occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the caused at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within To the comp	×	29b. Signature and title of fertifier	29c. License number		Date signed (Month, L	
	2		- Colon	D0060117	de	m 16,2001	t
	Q		30. Name and address of person who completed cause of death (Item 23a) (Ty				
			Eric Park, MD 9901 Medical Center	Drive, Rockville, M!	20850		
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sparks"			

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Ce</i>	artment <i>rtificate</i>	of H	lealth a <i>Death</i>	and M	fental Hy	/gien Reg. N		04	03924
			1. Decedent's Name (First, Mid	dle, Last)							2. Date of D	eath			3. Time of Death
	Physic /Medi		John Thomas	Perone Sr.							Month Januar	y 17		Yeer 104	12:12 p <sup>M</sup>
1	Exami		4e. Fecility Name (If not instituti	on, give street and n	umber)		4b. City, 7	own, o	r Location o	of Death			c. County	of Deeth	
			Holy Cross H	ospita <b>l</b>			Silv	er	Sprin	ıg			Mont	gome	ry
	Funeral	-	5. Social Security Number	6. Sex 1⊠ M 2 ☐ F	7. Age (In yrs.		If Under	Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D				lece (State or Foreign
н	Director		577-09-2447	IZM ZUF	8.5	Yrs.					Jan. 1				nington, DC
	pur *	}	Usual Residence of Decedent  10a, State 10b, Coun	v	10c. Ci	ty, Town or Lo	ocation								0d. Inside City Limits
	faryli sho	5		•											1 ☐ Yes 2 ☑ No
	the A	ect	Maryland Mont	gomery	S	ilver :	Spring 10f. Zip					10a C	itizen of V	What Cour	
	with a or		10303 Colesvi	11a Daad					0.1			rog. o			My :
	ns 23	Funeral Director	11. Marital Status		cedent Ever in L	J.S. 13.		2090 ent of H		ain? (Sp	ecify Yes or N	0-		SA e - Americ	an Indian,
(0	ritar	F	1 ☐ Never Married 2 ☐ Ma	Armed F stried 1 ☐ Yes	2 X No		If Yes, speci	fy Cuba	ın, Mexican	, Puèrto	Rican, etc.)			ck, White,	
036	urs a	þ	3 ☑ Widowed 4 ☐ Divorce	od If Yes, G	ive Dates:		1 ☐ Yes 2	⊠ No	Specify:				Specify	∉Whit	e
21215-0036	72 hours atler death with the Maryland natural', or Itams 23a or 28a-1 show litsel Examinat must be notified at	Be Completed		ent's Education est grade completed	0	16a. Dece	dent's Usual	Occup	ation	t of work	ina	16b. I	Kind of Bu	usiness/In	dustry
21	2.0	npie	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use	retired	during mosi 1)	O WOIK	, ig	M	edica	al Ir	strument
	ed wi	Con			2	Med	chanic	a1 ]						Desi	gn
pu	fal Hy d oth		17. Father's Name (First, Middle						18. Mothe	r's Name	(First, Middle	, Maide	n Sumam	16)	
yla	ould Men arke	ို	Thomas								eth Sti				
Maryland	2 sh and le m		19a. Informant's Name/Relation								al Route Numb				
	and Health Im 27 her t		Carole A. Slenk	covich/ Da		9518	Biltm	ore	Driv		ilver S				
0	ges f of t		20a. Method of Disposition  1 Burial 2 Cremation		n State	semetery, crei	matory or oth	ner plac	(e)	Janua	ary 22			City or To	
tim	t. Pa fmen fant: njury		`4 □Donation 5 ☑Other		ment `	Cen	netery		- !		004				ing, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Menfal Hygiene. Important: If Item 27 Is marked other than "natural", or itams 23s or 28s-f show say injury or other traumatic event, the Medical Examinat must be notified at ance.		21. Signature of Funeral Service	e Licensee	Pai	F	2. Name and rancis	Addres J.	coll	ins	Funera.	1 Ho	me I	nc.	
			23a. Part 1. Enter the dise e.	or commencations that	agus and the dear								er S	pring	, MD 20901
			shock, or heart failure. Li	st only one cause on	each line.	ii. Do not en	er the mode	or dylin	g, such as	cardiac	л гөзрлацогу а	irrest,			Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	t Failu									V	leeks
*	Examiner				o (or as a consec										
4		i i	Sequentially list conditions, if any, leading to immediate	D	nary Ar		lsease							Y	ears
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	≺	,	,									
,	exect n and lal-tra	Exa	resulting in death) Last	c. Due to	o (or as a consec	uence of):								-	
68760,	icate be executed physician and the burial-transit	dical		d											
.89		a a													
Вох	death certific e attending p id for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		75						23d. Date	e of delive	гу
	deatl e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Preg	birth 2 □ Feta nant at time of c		]Ectopic pre ] Other (s <i>pe</i>						Mor	nth	Day Year
P.0	that the de ned by the a detached f	hys	9 🗆 Unknown	9□ Unk	nown										
	igned be det	ь Р	Part II. Other significant condi						en in Part I.		23e. Did	tobacco	use contr	ribute to th	e cause of death?
ord	w requires been sign should be		Prostate Carc	inoma with	n Metast	ases,	Anemia	a ,			1 🗆	Yes 2	₩ No	3 🗌 Prob	ably 4 □Unknown
Records,		Completed	Renal Insuffi	ciency, St	troke (Ju	ly 26,	2003)				24a. Was		24b. V	Vere auto	osy findings available inpletion of cause of
Ä	The ate h page	E				-						ormed? 2 🔯 No	] d	leath?	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	al					26. Place	of Death	(Check only				
of V	ding Physician: h. After this certific funeral director,	일	1 Yes 2 XNo	Hospital:	Inpatient 2 🛭	ER/Outpatier	nt 3□ DOA	Othe	er: 4 🗆 Nur	rsing Ho	me 5 🗆 Resi	dence	6 Othe	er (Specify	)
			27. Manner of Death 1 XNatural 5 ☐ Pend	ing 28a. Date	of Injury nth, Day Year)	28b. Time of Injury	f 28	c. Injury Work	at c?		28d. Describe	how inju	ry occurr	ed	
sio	Attending it death. ector: Atterby the fune	cati	2 Accident inves	tigation			М		Yes 2 1	No					
Division	I or Attendi after death. Director: A	Certification:		mined 280. Plac	e of Injury - At h ding, etc. (Specii	ome, farm, str y)	eet, factory,	office		1	28f. Location ( City or To			er or Aura	Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		75.0												
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	(Check only 2 Medica	ing Physicien: To the Exeminer: On the	basis of examina	wledge, death ition and/or in	n occurred a vestigation, i	t the tim	ne, date and pinion, deat	d place, a h occurr	and due to the ed at the time,	cause(s date an	) and mai d place, a	nner as stand due to	ated. the cause(s)
	the the mplel	Med	one) 29b. Signature and title of certif	and ma	nner stated.				number						
	1		296. Signature and title of Certification of Certificatio	w 10	12.75	do						zau. Da	ne signed	i (NIUIIII), L	Day, Year)
	6			<b>y</b>		1		D08:	188			Ja	nuary	y 19,	2004
			30. Name and address of perso			1		, ,	_						
	Sta	ate	Hugo Graziani 31. Date filed (Month, Day, Yea	m.D. /1	7 Persh: Røgistrar's Signa	ing Dri				ring	, MD 20	1910			
	Regist		IAN 2	2004	ceneva	19	100	cks	1						

State of Maryland / Department of Health and Mental Hygiene « Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:20 am Rocco Anthony Panetta January 20. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery Olney Montgomery General Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 5. Social Security Number 6 Sex **Funeral** Days Hours 1⊠M 2□F 577-38-0696 84 July 31, 1919 Washington, DC Director Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City. Town or Location 10d Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 1 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3340 Chiswick Court Items 23a 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced er than "nature, the Medical E Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Teresa Scagnelli ဂ Gabriel Panetta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth L. Panetta/Sister 3340 Chiswick Court, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location · City or Town, State January 24, 2004 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee illia 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 24 hours Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the a detached Division of Vital Records, P.O. 9 Unknown 9 Tilnknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure, Cardiomyopathy 1 ☐ Yes 2 🖾 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□ No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 XNo Certification: To this in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ! 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certified To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number hur a Rosi my D24543 January 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi M.D 3305 North Leisure World Blyd., Silver Spring, MD 20906 31. Date filed (Month, Day, Year) JAN 21 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Dev **Physician** RUTH MATHEW PHIPPS FEB.3,2004 7:05P.M /Medical 4a Fecility Name (If not institution, give street and number, 4h. City. Town, or Location of Deeth 4c. County of Deeth Examiner CHARLES CO.NURSING & REHAB.CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthdey) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 257F 82 Director 229-16-3604 SEPT.9,1920 VIRGINIA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show the Medical Examiner must be notified a 1 TrYes 2 □ No Funeral Director MARYLAND CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5 10200 LA PLATA ROAD 20646 U.S.A. 238 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filad within 72 hours aftar on the filad within 72 hours aftar one of Haath and Mantal Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ŏ Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mantal P BENJAMIN FOLEY MATHEW IVA DORA ANDERSON 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dapartment of Haalth a important: if Item 27 is any injury or other tree 38228 GOLDEN BEACH RD. MECHANICSVILLE, MD. ace of Disposition (Name of Date 20c. Location - City or Town, State 20659 THOMAS A.PHIPPS-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) SUDLEY METH. CHURCH CEM. 2-6-04 MANASSASS, VA. 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 LA caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest each line. 23e. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Betwee Onset and Deat **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner usa as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of) attanding physician and Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) resulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Nio 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1000 funeral diractor, 25. Was case referred to medical Be. 26. Place of Death (Check only one) Other: Aconursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? s after deam. 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospital within 24 hours a To the Funeral Complataly filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title/of certifier 9 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Old line 120 4 PLAUCOD M. Chael 3. Registrer's Signature 31. Dete filed (Month, Day, Year) State FEB 1 0 2004 Registrar

		For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	rtment of I	Health and I Death	-	Reg. No.	2004	03927
Physicia	ın	1. Decedent's Name (First, Middle, Last) Columbia		D.		Pontori	10	2. Date of De		Year	3. Time of Death 9:05 A M
/Medic Examin	_	4a. Facility Name (If not institution, give st		oer)		4b. City, Town,	or Location of Death		4c. C	County of Death	
		Bradford Oaks Nur  5. Social Security Number 6. Sex			ast birthday)	Clint			th .	ince Ge	place (State or Foreign
Funeral Director			M 2 <sup>2</sup> E¥F	Age (In yrs. &	Yrs.	Months Days	Hours Min.	09/10/6/1	914)	Wash	ington, DC
and bw		Usual Residence of Decedent  10a. State 10b. County			, Town or Lo	cation					10d. Inside City Limits
e Mary	ţċ	Maryland Charles		Wa	ldorf						1 Tes XXXXV
with the	Dire	10e. Street and Number 774 University Dr	i ve			10f. Zîp Code 2060	12		10g. Citize	en of What Cou USA	ntry?
death	Funeral Director			ent Ever in U.S	S. 13. V	Vas Decedent of	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	4. Race - Ameri Black, White,	
ine, intellylating ZIZIO-000 stand 2 should be filed within 72 hours after death with the Maryland of theath and Mental Hygiene. If heath and Mental Hygiene. other 21 is marked other than "netural", or items 23e or 28e-f show other traumatic event, the Medical Exercitivation to indiffer a	by Fu	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	1   Yes 2 If Yes, Give Year or Date	<b>₩</b>		□Yes ¾[X]No		,	s		hite
2-00 72 hou netura	eted	15. Decedent's Educ	ation		(Give	ent's Usual Occu	during most of wor	king	16b. Kind	d of Business/In	dustry
within within than than than than than than than tha	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. L	oo not use retire etary	ed)		Feder	ral Gov	ernment
d be filed ontal Hygi ad other c event, L	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Nar				<del>-</del>
yidi nould b d Menta narkad natic e	ဥ	Gervasio M		)	10b Mailin	a Address (Stree	t and Number or Ru	Maria			n Code)
Man nd 2 st allth and 27 ts n r traun		19a. Informant's Name/Relationship (Type Jim Pontorno / So			E		ty Dr. Wa				0602
of Her of Her if item		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	moval from St		ace of Dispos emetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Loc	ation - City or T	
Dallillor permit. Pages Department of P Important: If ite any injury or of once.		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Far ral Service License,		Res		ion Cem		1/2004		nton, Ma	
Dall permit. Departi Import any inj		ANP. Na	los		6	160 Oxo	ess & Facility n Hill Ro	P. Kalas ad Oxon	Hill Hill	eral Ho , Maryl	me P.A. and 20745
		23a. Part 1. Enter the disease, o complic shock, or heart failure. List only on	ations that cause cause on each	used the death ch line.	. Do not ente	er the mode of dy	ing, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	ueutA						- 5	I west.
Examiner		Sequentially list conditions. b.									
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	ence of):							
of ou, cate be executed physician and the burial-transit		that initiated events coresulting in death) Last	Due to (o	r as a consequ	ience of):						
cate be e	dicai	d.									
cords, F.C. BOX 00/00, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23		ome of pregnar th 2 ☐ Fetal		Ectopic pregnan	3/		23	3d. Date of deliv	•
the atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ № 9 ☐ Unknown		nt at time of de		Other (specify)				Month	Day Year
requires that the	by Ph	Part II. Other significant conditions conf	-	ith but not resu	ulting in the ur	iderlying cause g	iven in Part I.	23e. Did t	obacco us	e contribute to I	he cause of death?
ords require sen sig	ted b	AIZHeimers Di	eory						Yes 2.17		bably 4 □Unknown
has has	Completed								osy rmed?	death?	opsy findings available ompletion of cause of
_ bat d	Be Co	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o	2⊠XIo ne)	1 ☐ Yes	2 L No
Or VICA Phyaicien: this certific ral director,	٩	examiner? 1 ☐ Yes 2 ∑XSo  27. Manner of Death	ospital: 1 □ Inj 28a. Date of	patient 2 1	ER/Outpatien	1 3 DOA	The state of the s	lome 5 Resi			fy)
Attending F or death. rector: Atter by the funer.	ation	1 Natural 5 Pending 2 Accident investigation	(Month	Day Year)	Injury	W	ork? □Yes 2□No	200. 20001120	ion injury	33341734	
DIVISION  for Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	of Injury - At ho	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,
DIVISIO DIVISION Attendi 124 hours after death. 16 Funeral Director: A	al Ce	29a. Certifier 1 Certifying Phys	cian: To the b	est of my know	wledge, death	occurred at the	time, date and place	, and due to the	cause(s) a	and manner as s	stated.
To the Hospital or Attending Physicien: within 24 hours after death within 25 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Check only 2 ( Medical Examin	er: On the bas and manne	sis of examinater stated.	tion and/or in			irred at the time,			
To To com	Σ	29b. Signature and title of certifier	me.	~			SZO6		_	signed (Month,	•
[7]		30. Name and address of person who con	npleted cause	of death (Item	23a) (Type,	Print)	-			my 19, 2	
- ( //	•	William T. TANA 31. Date filed (Month, Day, Year)	20 Do	aintror's Signal	turo		Rod For	r WASHing	tun u	horylmo	l
Sta Registr		JAN 2 0 2004	Bed	المريع معالماني المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم	hos	W					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8.05pM Janus 2004 Robert Scott Parks 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham Doctors Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/31/62 If Under 1 Year Months Days 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1**∑**M 2□F 41 Virginia Director 236-11-1352 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Prince Georges Bowie 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number ŏ filed within 72 hours after death with USA or Items 23a 10417 Vista Gardens Drive 20720 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Manager 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Academy Ford Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 Is marked other then College (1-4or 5+) Manager Elementary/Secondary (0-12) Business Developing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernice Granthan Charles Raymond Parks other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, MD 20720 Barbara Parks/wife 10417 Vista Gardens Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Glenwood Cemetery 1/23/04 Washington DC 21. Sign was of Fundral Service Livensee 22. Name and Address of Facility Henry Funeral Chapel Inc. H Street NE Washington DC 20002 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner (or as a consequence of the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | the be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 TYes 2□ No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature ar the of certifier 29c. License number 118 Good 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 20, 2004 9:50 AM IDA ROSENHEIM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 1923 WASHINGTON, DC 80 579-20-0959 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Exeminer must be notified at SILVER SPRING 1 XYes 2 No ĕ MONTGOMERY MARYLAND Direct 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number items 23a UNITED STATES OF AMERICA 20901 MALTA LANE 816 death , Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or ite eny injury or other treumatic event, the Medical Examina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo Specify: Specify: ۾ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES GENERAL College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING OFFICE EDITOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NELLIE SHUSTER ISADORE KATZMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SIDNEY ROSENHEIM - HUSBAND 816 MALTA LANE, SILVER SPRING, MD 20901 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 01/22/04 JUDEAN MEMORIAL GARDEN OLNEY, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC Donald 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERTENSIVE HEART DISEASE /Medical Due to (or as a consequence of) Examiner CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit **PNEUMONIA** Due to (or as a consequence of): P.O. Box 68760. physician ALZHEIMERS'S DEMENTIA Physician/Medical the ! as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown ACUTE RENAL FAILURE Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 ho 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 XInpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐XNo 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XVatural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10x11 12 nounas D47330 JANUARY 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS V. JOSEPH, MD, 50 WEST EDMONSTON DRIVE, ROCKVILLE, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 22 Registrar

			For State Registrar	State of Maryland		artment ortificate			ind M		iene	04	03930
			Decedent's Name (First, Middle, Last)							2. Date of Dea			3. Time of Death
	Physici		Sharon D. Roark						b	Month Sanuary	Day 21 20	Year 004	1:45 P M
н	/Medio Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, To	wn, or l	Location of	f Death		4c. County	of Death	
			12301 Tree Top Dri	ve #44		Silv	er	Sprin	ıg		Mont	gomer	У
	Funeral Director		5. Social Security Number 6. Sex		t birthday) Yrs.	If Under 1 Months C	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Dec. 14	, 1951	Cour	lace (State or Foreign htry) ESSEE
	D		Usual Residence of Decedent										
	rylan thow		10a. State 10b. County		Town or Lo	Spring						1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	Ba-f s	Director	Md. Montgome	:1 y 313	LVEL .	<del>-</del>							
	or 2	ä	10e. Street and Number	, , ,		10f. Zip Ci					0g. Citizen of \		•
	ath v		12301 Tree Top Dri		10.1		2090				Jnited		ean Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examers must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 197 If Yes, Give Year or Dates: to 19	77	was beceder f Yes, specify 1 ☐ Yes 2 ☑		Specify:	, Puerto F	cify Yes or No- Rican, etc.)	Blac	ck, White,	etc.
ᅌ	thou stura	- G	15. Decedent's Edu	cation	16a. Dece	dent's Usual (	Occupat	tion			16b. Kind of Bu	usiness/In	dustry
Maryland 21215-0036	within 72 ene. than "na he Media	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. Nurs	kind of work of NOT use	done du retired)	ıring most	of workir	ng	Nursin	g	
9	filed withi Hygiene. other than ent, the M		17. Father's Name (First, Middle, Last)	2				18. Mother	r's Name	(First, Middle, I	Maiden Surnar	1e)	
an		To Be	Robert Earl Hughes	1				Be	rtha	Mae Ti	oton		
Ž	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	ng Address (S	Street ar	nd Number	r or Rura	/ Route Number	City or Town,	State, Zip	Code)
	2 t t 2 t 2 t 2 t 2 t 2 t 2 t 2 t 2 t 2		Shannon Koutavas	Daughter)	4003	Wedge	Cou	rt M	t. A	iry, Md	. 21771		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State cen	netery, crer	sition (Name matory or othe Ltan Ci	er place,	) J	an. 2	22,	20c. Location - Alexano		
Balti	permit. Pages 1 Department of H Important: If ite any injury or otl		21. Signature of Funeral Service Licens	ee Us		Name and A			рev	ol Fune r. Gaitl	ral Hom nersbur	ne g, Mo	1. 20877
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	calions that caused the death.	Do not ent	er the mode o	of dying,	, such as c	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician	2	Immediate Cause (Final	AGI V	1							1	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):							00	11/2
н	Examiner		Sequentially list conditions										
		ē	if any, leading to immediate	Due to (or as a conseque	nce of):								
	cuted nd ransi	Examine	cause. Enter Underlying Cause (Clause or injury that initiated events										
oʻ	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):								
8760,	ate b hysic the bi	dicai		l				,					
9	ertific ing p	Med	IF FEMALE:	0 1/									
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 220 No 9  Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic preg Other (speci			···		23d. Dat Mo	te of delive nth	ny Day Year
<u>G</u>	that the ed by detac		Part II. Other significant conditions cor	tributing to death but not result	ing in the u	nderlying caus	se aiver	n in Part I.		23e. Did tol	acco use cont	ribute to th	e cause of death?
rds,	quires t in signe uld be	ed by								1 □ Ye	s 2 No	3 🗌 Prob	ably 4 DUnknown
of Vital Record	The law requires that the sate has been signed by the page 2 should be detache	Completed								24a. Was a autops perform	y negi?	Were auto prior to con death?	psy findings available inpletion of cause of
ta		a	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes 2	-	103	20110
>	Phyaician: this certific ral director,	.0 B	examiner? 12 Yes 2 □ No	ospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatien	t 3 DOA	Other	4 □ Nur	sing Hon	ne K Reside	nce 6 Oth	er (Specify	()
	g Phy erthi	=	27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time of	28c	. Injury a	at	2	8d. Describe ho	w injury occurr	ed	
<u>0</u>	Attending I or death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Say 1 Say	111,019	М		es 2□N	10				
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, o	ffice		2	8f. Location (St. City or Town		er or Rura	l Route Number,
	Hospii 4 hour Funera tely fill	Medical C		sicien: To the best of my knowler: On the basis of examination and manner stated.									
	To the within 2 To the comple	ž	29b. Signature and title of certifier				icense			2	9d. Date signed	(Month,	
l	1		My DO	een moi	WE	10	99	75 E	5,		Tan 2	2	2004
	3+1		30. Name and address of person who co	mpleted cause of death (Item 2 HtR moom			01	70	cir	(al P	1 20°	302	
	Sta Registr	_	31. Date filed (Month, Day, Year)  JAN 23 201	32. Registrar's Signatur	9	Spa	Ks	1		/			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician January 19, 2004 Patricia Anne Reidenbaugh 8:15 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗓 F Yrs Director 188-24-3755 72 Pennsylvania May 18, 1931 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer death with the Meryland Depertment of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Be Completed by Funeral Director Virginia Fairfax McLean 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1504 Lincoln Way #204 22102 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: Specify: White 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard Crist Claudia Rokosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Andrew Reidenbaugh/Son 1555 Sunstone Dr., McLean, Va. 22102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/27/04 Alexandria Va. 22. Name and Address of Facility
MONEY & KING FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 171 W. Maple Ave., Vienna, Va. 22180 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Physician MYOCARDIAN INFARCTION Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed After this certificate hes been signed by the ettending physician end funeral director, page 2 should be deteched for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 You 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural nours effer death.

neral Director: Af
y filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely and manner stated. 29c. License number death (Hem 23g) (Type, Print) MO 6/21 Montrose Rd Rockville, MD

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 23

2004

32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician JERRY** VINCENT CHUON 12 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 24 Hrs. Sex 1 M 2 □ F If Under 1 Year 8. Date of Birth (Month, Day, Year) Sept. 6,1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 79 131-14-6379 Yrs. Director New York Usual Residence of Decedent death with the Merylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylen Department of Heelih end Mental Hygiene. Important: If item 27 ie marked other than "naturel", or items 23a or 28a-f show any hours or other traumatic event, the Medical Examinet must be notified at app.8. 1 X Yes 2 ☐ No Funeral Director Md. Montgomery Gaithersburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Quince Orchard Blvd. #T2 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ۾ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government Printing Elementary/Secondary (0-12) College (1-4or 5+) Proof Reader 12 Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Raso Jennie Murano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Quince Orchard Blvd. #T2 Gaithersburg, Md. 20878 Marilyn S. Raso (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan.12, 2004 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complicatifins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or/as a consequence of) by Physician/Medical Examiner nding physicien end use es the burial-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 30 No Inpatient 2☐ ER/Outpatient 3☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After third in by the funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident investigation efter death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours e To the Funeral D the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature/and-title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles 32. Registrar's Signature 31. Date filed (Montl State 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16, 2004 Lhanderdage Kagbir JAN. 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Yrs. JAN. 25,1928 Director 580-02-5770 TRINIDAD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits \*show the Medical Examiner must be notified at 1X Yes 2 No Directo MD. PRINCE GEORGES BELTSVILLE 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.Ş.A. 12504 CALVERT HILLS DR. 20705 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 Specify: WEST INDIAN 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEWIFE AT HOME permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 Is marked other it
any injury or other traumatic event, IIIs
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOCOOL RAMPIARI RAMHARRACK BALKISSOON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NAITHRAM RAGBIR/HUSBAND CALVERT HILLS DR., BELTSVILLE, MD. 20705 12504 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-19-2004 RIVERDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. Chan EUGA M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** only lowercal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2D No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA this 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? Director: After that in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined within 24 hours after dear To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and till of certifier 29c. License number 20100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 SHADY GROVE RD. #206, ROCKVILLE, MD. 20850 MARK ROSEN, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 0 2004 Registrar

			1 - For State Registrar		ryland / Dep		lealth ar	nd Mental Hygi	iene 2004	03935
			Decedent's Name (First, Middle, Las	t)				2. Date of Death	1	3. Time of Death
	Physicia		Philip Stephe	en Rado	c			January	Day Year 15 2004	1:10 A M
	/Medic		4e. Facility Name (If not institution, give			4b. City, Town, o	r Location of I		4c. County of Dea	
	LXUIIII		Shady Grove Adv	entist Hos	nital	Rockvi	11e		Montgome	rv
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthda	) If Under 1 Year	If Under 24			thplace (State or Foreign
	Director		578-09-8738	<b>Ж</b> м 2□F	84 Yrs.	Months Days	Hours	Min. (Month, Day, Aug. 31	, 1919 Mar	yland
7			Usual Residence of Decedent							,
rylar	how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
e Ma	A Sart	cto	Maryland Montgome	ery	Derwoo	d				1 ☐ Yes 2 🖸 No
ih th	or 20	Oire	10e. Street and Number			10f, Zip Code			g. Citizen of What Co	
tt w	23s	by Funeral Director	7713 Yellowston	e Way		2085.			United Sta	ites
r de	tams Mr.E.	ne	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Originan, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
s afte	or I	Y.	1 Never Married 2 Married	1 XYes 2 □ N If Yes, Give	· 1942–	1 ☐ Yes 2 No	Specify:		Specify:	
on in	ural'		3 Widowed 4 Divorced	Year or Dates:	1946				Wn	ite
72	"nat	Completed	15. Decedent's Ed (Specify only highest grad		(Giv	edent's Usual Docup re kind of work done DO NOT use retired	during most o	f working	6b. Kind of Business	/Industry
Mitigal N	than	E G	Elementary/Secondary (0-12)	College (1-4or 5	+)		2)	3.		
led A	Hygie nt, II	ပိ	17. Father's Name (First, Middle, Last)	2	Mal_	Clerk	18 Mother's	Name (First, Middle, M	lewspaper	
ed i	ed o	Be		odos				Bellos	alour burnamo,	
at y lated Z 1 Z 13-0030 should be filed within 72 hours after death with the Maryland	d Me mark matic	<sup>L</sup>	Stephen George R  19a. Informant's Name/Relationship (7		19b Ma	lina Address (Street		or Rural Route Number,	City of Town State	Zin Cada)
Ma d2s	th an									
בי קר פ	Heath		Patricia D. Rado  20a. Method of Disposition	s / Wife	20b. Place of Dis	Yellowst	one wa		Maryland Oc. Location - City or	
Pages	15 m		1 ☐ Bunal 2 【ACremation 3 ☐		cemetery, cr	ematory or other place	1 4	Jan. 15,		
DAILING Bermit. Pages	niun		* 4 □ Donation 5 □ Other (Specify  21. Signature of Juheral Service Licen	A		itan Crema 22. Name and Addre				, Virginia
8 5	Department of Health and Mental Hygiene. Important: or Itams 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Purieral Service Licent	300				DeVol Fune:	ral Home rsburg, M	20977
			23a Part 1 Foto the diserse or come	VV V	The second secon	O E. Deer			0.	Approximate
	- F.		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of tmmediate Cause (Final	one cause on each lin	e.	men the mode of dyn	ig, sucii as ca	idiac or respiratory arre	51,	Interval Between Onset and Death
	nysician		disease or condition resulting in death)			insar	ction			Minutes
	Medical xaminer		<b>1</b>	Due to (br as a	a consequence of):					
	e .	1-	Sequentially list conditions,	b. Due to (or as	a Consequence of):	er				month
pe	sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D00 to (0) as t	consequence or).					
ou, be executed	and I-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as a	a consequence of);					
		calE	4.							
The law requires that the death certificate	phys s the			d						
Certif	ding se a:	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of del	
aath C	atten for u	ian	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date of del Month	Day Year
) §	the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	in or douting	Cirial (apocity)	-			
that	ed by deta		Part II. Other significent conditions co	ontributing to death bu	it not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
requires	sign d be	d by						1 ☐ Yes	s 2 No 3 Pr	obably 4 Munknown
5 §	been	Completed						242 145		/\
	has Je 2	шp						24a. Was an autopsy	prior to	itopsy findings available completion of cause of
# #									No 1 ☐ Yes	25 No
VILCIII	certificate has t	Be	25. Was case referred to medical examiner?	Hospital:		045		Death (Check only one	)	
Phys	this ald the	2	1 ☐ Yes 2 ŒNo  27. Manner of Death	1 _ Inpatie			4 LI NUISI	ng Home 5 Resider		cify)
ing in	h. After funera	ion	1 ☑ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	Wor	k?	28d. Describe how	v injury occurred	
	death tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, s		Yes 2 □ No		and Aliceber of D	and Pouts Nambos
٥ م د ۲	Direction by	ertif	4 ☐ Homicide determined	building, etc	. (Specify)	treet, ractory, onice		City or Town,	eet and Number or Ru State)	ira/ Houte Number,
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	valcian: To the best of	if my knowledge de-	ath occurred of the fi	no data and	place, and due to the car	una(a) and mr.	atatad
Hos	24 ht Fun stely	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination and/or	nvestigation, in my o	pinion, death	place, and due to the car occurred at the time, da	use(s) and manner as te and place, and due	to the cause(s)
o the	o the	Me	29b. Signature and title of certifier	and mainer sta		29c. Licens	e number	29	d. Date signed (Monta	h, Day, Year)
			100	7		~ -			\ .	1.60
	8		( Cleval )	reule	MD	1031	979		pornucu	115,2004
			30. Name and address of person who o	completed cause of de	Pain (Item 23a) (Type	e, Print)		r ROCKUII	V	V.13
nty	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	edicalce	enter D	r rockuil	16 ms an	5≫
	Ponietr		IAN 2.0 20	114 Sens	va 19	Loak				

		1	For State Registrar	State of	of Marylar	nd / Depa <i>Cei</i>	rtment of H tificate of I	ealth and Death	Mental Hy	giene / Reg. No.	2004	03936
	Dhuaiais		1. Decedent's Name (First, Middle,						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al	Denzil Ruth Ram						January	·		10:56 P M
	Examin		4a. Facility Name (If not institution, g St. Mary's Hosp		imber)		4b. City, Town, or Leonard		atn		ounty of Death t. Mar	
				Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H				nplace (State or Foreign untry)
	Funeral Director		509-18-2152	1 ☐ M 2 🗓 F	84	Yrs.	Months Days	Hours Mi	n. (Month, Da January	<i>y, Year)</i> 1 <b>,</b> 1920	Ka	nsas
	ס	-	Usual Residence of Decedent		110. 0	. 7						10d. Inside City Limits
	arylar show	.	10a. State 10b. County			ty, Town or Lo						1X Yes 2 □ No
	Ba-f	ecto	Kansas Sumner  10e. Street and Number		we.	11ingto	10f. Zip Code			10a Citize	n of What Co	untry?
	with	Funeral Director	400 S. "C" Stree	+ #312			67152			-	SA	,
	ns 23	era	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No	- 14.	Race - Ame	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show important: if item 27 is marked other than "naturel", or items 23a or 28a-f show important or other treumstic event, the Medical Evantion must be nutified at anone.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F d 1 Tyes If Yes, G Year or I	2 X No ive		f Yes, specify Cuba 1 ☐ Yes 2 💆 No	Specify:	erto Rican, etc.)		Black, White Decify: Wh	
Þ	2 hor	ed	15. Decedent's	Education	)	16a. Dece	dent's Usual Occup	ation during most of w	vorkina	16b. Kind	of Business/	Industry
Maryland 21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done of DO NOT use retired	)		Banki	no	
2	ygier ygier her th		12			bank	Clerk	18 Mother's N	lame (First, Middle			
and M	be fill hd ott	Be	17. Father's Name (First, Middle, La Gilbert Howard N						tta Howai		,,,,,,,,,	
Ž	d Mer d Mer marke	2	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street				own, State, 2	Zip Code)
Ma	id 2 s lth an 27 is i		Andrea Day/Daugh				7. 20th S					
ē,	s 1 an f Heal ftem other		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place	:e)	Date	20c. Loca	tion - City or	Town, State
e E	Pages ent of nt: # i		1 X Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		n State	orne C	emetery	01/	/30/2004			
Baltimore,	permit. Departm Importe any inju		21. Signature of Funcial Service Li	ense		22	2. Name and Addre	ss of Facility Ma	attingley-G k 270 Leona	arliner rdtown,	F nera MD 206	1 Nome, P.A. 50
			23a. Part1 Enter the disease, or c	omplications that	caused the dea	ith. Do not en	er the mode of dyin	g, such as card	lac or respiratory a	rrest,		Approximate Interval Between
	Physician		shock, or heart failure. List o			andial	infarct					Onset and Death
	/Medical		disease or condition resulting in death)	a. Acu Due to	o (or as a conse	quence of):	Till al Cc					
ı	Examiner		Sequentially list conditions,		te pulm		embolus					
-	ם ב	iner	if any, leading to immediate cause. Enter Underlying	Oue to	o (or as a conse	quenca of):						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse	quence of):						
8760,	cate be executed physician and the burial-transit	alE			(4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4	4						
587		edical		d								
Box (	nding use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Testania aragagas			23	d. Date of del	
Ď.	death e atte	lcla	in the past 12 months? 1 □ Yes 2 ☒ No		birth 2 Fet gnant at time of		□Ectopic pregnancy □ Other (specify) _				Month	Day Year
P.O.	at the by th	hys	9 🗆 Unknown	ļ					l age pid	<b></b>		the cause of death?
Division of Vital Records, I	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a		Renal Insufficient Condition	•	death but not re	sulting in the u	inderlying cause giv	en in Part I.				robably 4 Unknown
O O	s bee	Completed	Congestive Hear	t Failur	e				24a. Was		24b. Were au	utopsy findings available completion of cause of
Re	The lav	E O								2 No	death?	2 □ No
ita		Bec	25. Was case referred to medical examiner?					2.5	Death (Check only	one)		
× ×	S S	2	1 ☐ Yes 2XXVo		,,,	ER/Outpatie		4 LI NUISIN	g Home 5 ☐ Res			cify)
n c	fer fer	e ii	27. Manner of Death  XX Natural 5 ☐ Pending	(Mo	e of Injury onth, Day Year)	28b. Time o	Wo	yat k? Yes 2 ⊟No	28d. Describe	now injury	occurrea	
Sio	Attending r death. ector: After by the fune	icat	2 Accident investigation inves	ot be 200 Blo	ce of Injury - At	home farm st	reet, factory, office	765 2 140	28f. Location	Street and	Number or Ri	ural Route Number,
$\frac{1}{2}$	after of Direction by	Certification;	4 Homicide determin	ied 200. Flai	Iding, etc. (Spec	cify)	reet, factory, office		City or To	wn, State)		
_	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1XX Certifying (Check only 2 Medical E	xaminer: On the	he best of my kr basis of examir	nowledge, dea nation and/or in	th occurred at the tinvestigation, in my	me, date and pla opinion, death o	ace, and due to the courred at the time	cause(s) a date and p	nd manner as lace, and due	s stated.  to the cause(s)
	o the o the o the omple	Med	29b. Signature and title of certifier	31101111			29c. Licens	se number		29d. Date	signed (Mont	th, Day, Year)
	- > - 0		1/2	$\sim$			1)5	6096		Janu	ary 23	3, 2004
			30. Name and address of person v	vho completed ca	use of death (Ite	em 23a) (Type	Print)	S 1to	LiyWoo			20636
	St Regist	ate rar	31. Date filed (Month, Day, Year)	0 3 2004	Registrar's Sign	nature	Sports					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 1344 P M January 2004 Estiss Eugene Reedy /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Union Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2 □ F Director 224-44-2487 63 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or then "natural", or Items 23s or 28e-f show the Medical Exemples must be notified at 1 ☐ Yes 2 N No Director Maryland Cecil Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 652 Frenchtown Road 21921 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1956 1 ØYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give CO Year or Dates: 1957 Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Production Plastic Manufacturing other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill f Health and Mental H Item 27 is marked oth Be Idabelle Dye 2 Walter Lee Reedy item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 652 Frenchtown Road, Elkton, Maryland 21921 Bertha M. Reedy/Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gilpin Manor Pages 0 = February 4, 5 permit. Page Department of Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Elkton, Maryland Memorial Park 21. Signature of Funeral Service 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated wants to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran that initiated avants resulting in death) Last Que to (or as a consequence of) Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ned by the a P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Completed been 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 1 ☐ Yes Physicien: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 Y ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) 29b. Signature and little of 66 29c. License numbe 29d. Date signed (Month, Dev. Year) who completed cause of death (Item 23a) (Type, Print) 30. Name ar Mulvey, West High Street, Suite 314, Elkton, Maryland 21921 M.D., 111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

FEB 1 0 2004

		1. Decedent's Name (First, Middle,		a-1,Per ME,G828	3 / 4 / 0 4 Reg. 2. Date of Death Month	Day Yeer	3. Time of Death
Physicia /Medic	al	Ezorion Juan		· · · · · · · · · · · · · · · · · · ·	JAN. 22	2, 2004	0959 A
Examin	er	4a. Fecility Name (If not institution, WASHINGTON ADVE		4b. City, Town, or Location of Dea TAKOMA PARK		4c. County of Death MONTGOMERY	
Funeral Director		5. Social Security Number 212-69-2572  Usual Residence of Decedent	5. Sex 1  M 2  F  Yı.	Months Days Hours Min		9. Birthp Coun Mary	lece (State or Fore
Mo Tal		10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limi
r 28a-f show	tor	MD Prince	George's	College Park			1)X Yes 2 □ I
23s or 28	i Director	10e. Street and Number 4716 Lakeland Ro	1.	10f. Zip Code 20740		Citizen of What Coun	ntry?
ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ Black, White,	
natural', or itema 23s or 28a-1 show digal Examinar must be notified at	2	1 <b></b>		1 ☐ Yes 2 ☐ No Specify:	to ritidali, etc.)	Specific	ack
"natural"	etec	15. Decedent's (Specify only highest	Education 16a. C	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired)	nrking 16t	o. Kind of Business/Inc	dustry
than	Completed	Elementary/Secondary (0-12) N/A	College (1-4or 5+)	ife. DO NOT use retired) N/A		N/A	
Hygi ther nt, L	ပိ	17. Father's Name (First, Middle, La	ast)		me (First, Middle, Mai		
	To Be	Joshua	Johnson	Ebon		Rand	
27 is r tra		19a. Informant's Name/Relationship PatriceJewell/	Aunt 383	Mailing Address (Street and Number or A 39 64th Ave. #310 H	yattsville	, MD 207	
		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State cemetery,	Disposition (Name of crematory or other place)  ad National 1		aurel, MD	own, Stete
Department Important: If any injury o		21. Signature of Funeral Service Li	riaryran	22. Name and Address of Facility J	.B. Jenkin	s Funeral	
13.5		23a. Part1. Enter the disease, or co	omplications that caused the death. Do no	7474 Landover Kd.	Landover	, MD 20785	
				et enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate
A 100 A 100 A	l d	Immediate Cause (Final		t enter the mode of dying, such as cardia	c or respiratory arrest,		Interval Between Onset and Death
nysician Medical	į ń		_a. Asphyxia		c or respiratory arrest,		Interval Between
		Immediate Cause (Final disease or condition resulting in death)			c or respiratory arrest,		Interval Between
Medical xaminer	Iner	Immediate Cause (Final disease or condition resulting in death)	a. Asphyxia  Due to (or as a consequence of	):	c or respiratory arrest,		Interval Between
Medical xaminer	caminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Asphyxia  Due to (or as a consequence of b. Overlay  Due to (or as a consequence of c.	):	c or respiratory arrest,		Interval Between
Medical xaminer	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Asphyxia  Due to (or as a consequence of  b. Overlay	):	c or respiratory arrest,		Interval Between
Medical xaminer prize transit	cai	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Asphyxia  Due to (or as a consequence of b. Overlay  Due to (or as a consequence of c.	):	c or respiratory arrest,		Interval Between
Medical xaminer prize transit	cai	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of d.	):	c or respiratory arrest,		Interval Between Onset and Death
Medical xaminer prize transit	cai	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of c.  Due to (or as a consequence of d.	):	c or respiratory arrest,	23d. Date of delive	Interval Between Onset and Death
Medical xaminer prize transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of c.  Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)	23e. Did tobac	23d. Date of delive Month	ory Day Year
Medical xaminer prize transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. Due to (or as a consequence of Overlay  b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	23e. Did tobac 1 □ Yes	23d. Date of delive Month  co use contribute to th	ony Day Year  he cause of death? hably 4 Unknown
ate has been signed by the attending physicien and an page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. Due to (or as a consequence of Overlay  b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	23e. Did tobac	23d. Date of delive Month  co use contribute to th  2No 3 Prob  24b. Were autoprior to cordeatt?	eny Year  Day Year  Day 4 Unknows  psy findings availa
ate has been signed by the attending physicien and an page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consequence of Overlay  b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	):  3 □Ectopic pregnancy 5 □ Other (specify)  the underlying cause given in Part I.	23e. Did tobace 1	23d. Date of delive Month  co use contribute to the 22No 3 prob 24b. Were autoprior to cordeath?	ory Day Year  ne cause of death?  ably 4 Unkno
this certificate has been signed by the attending physicien and director, page 2 should be detached for use as the buriat-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Asphyxia  Due to (or as a consequence of Overlay  b. Overlay  Due to (or as a consequence of ot or as a consequence of ot or other or other o	):  3 □Ectopic pregnancy 5 □ Other (specify)  the underlying cause given in Part I.  26. Place of De other: 4 □ Nursing is	23e. Did tobac  1  Yes  24a. Was an autopsy performec 1  Xes 2  ath (Check only one) Home 5  Residence	23d. Date of delive Month  co use contribute to the 2No 3 Probert Properties of the content of t	ory Day Year  ne cause of death?  ably 4 Unkno
After this certificate has been signed by the attending physicien and mineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of Due to (o	3   Ectopic pregnancy 5   Other (specify)    the underlying cause given in Part I.  26. Place of De  valuent 3   DOA   Other: 4   Nursing II  underlying at Work?  1   Yes 2   XI No	23e. Did tobac  1  Yes  24a. Was an autopsy performed 1  Xyes 2  ath (Check only one)  Home 5  Residence 28d. Describe how in	23d. Date of delive Month  co use contribute to the 2 No 3 Prob 24b. Were autor prior to cordeath? No 1 Present the second secon	Pry Pay Year  Day Year  Day Year  Day 4 Unkno  Day findings availa  mpletion of cause of 2 No
After this certificate has been signed by the attending physicien and mineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Asphyxia  Due to (or as a consequence of Overlay  b. Overlay  Due to (or as a consequence of outline of or as a consequence of outline of or as a consequence of outline of outline outline of outline outline of outline outline of outline outline of outline of outline	3   Ectopic pregnancy 5   Other (specify)    the underlying cause given in Part I.  26. Place of De  patient 3   DOA    Other: 4   Nursing is  work?  1   Yes 2 X No	23e. Did tobac  1  Yes  24a. Was an autopsy performed to the conference of the confe	23d. Date of delive Month  co use contribute to the 22No 3 Probert Properties of death?  17 A Second Probert Properties of the pring wit:  18 And Number of Rura	ony Year  Day Year  Day 4 Unkno  psy findings availa  mpletion of cause of 2 No  Adult
After this certificate has been signed by the attending physicien and mineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of Due to (o	3 DEctopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of Decention of Dece	23e. Did tobac  1  Yes  24a. Was an autopsy performed to the control of the contr	23d. Date of delive Month  2 No 3 Prob  24b. Were autoprior to cordeatt? No 1 Pros  6 Other (Specify njury occurred ping wit)  t and Number or Rura (ate)	ony Year  Day Year  Day Year  Day Year  Day Grandings availa  mpletion of cause  2 No  No  No  Adult  Route Number,  Oad.
After this certificate has been signed by the attending physicien and mineral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Xeyes 2   No  27. Manner of Death 1   Natural 5   Pending investiga investiga   Investiga   3   Suicide   6   Could no determin  29a. Certifier   1   Certifying	Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of Due to (or a	3 Ectopic pregnancy 5 Other (specify)  the underlying cause given in Part I.  26. Place of De patient 3 DOA Other: 4 Nursing I Work? 1 Yes 2X No n, street, factory, office	23e. Did tobacc  1  Yes  24a. Was an autopsy performed. 1  Xyes 2  ath (Check only one)  Home 5  Residence 28d. Describe how in the case of the control of the control of the control of the case of the control of the case of the control of the case of the control of the case of the control of the case of the control of the case of the control of the case of the control of the case of the	23d. Date of delive Month  2 No 3 Prob  24b. Were autoring to correct death?  1 Pres  6 Other (Specify injury occurred ping with a correct death)  1 and Number or Rura (afe)  1 And Rural and Rura (afe)  1 And Rural and Rural (afe)  1 And Rural and Rural (afe)  1 And Rural and Rural (afe)  1 And Rural and Rural (afe)  1 And Rural and Rural (afe)  2 And Manner as \$1.50 And Manner as \$1	onset and Death  onset and Death
After this certificate has been signed by the attending physicien and mineral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Xeyes 2   No  27. Manner of Death 1   Natural 5   Pending investiga investiga   Investiga   3   Suicide   6   Could no determin  29a. Certifier   1   Certifying	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of Overlay  Due to (or as a consequence of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of of or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or as a consequence of or or or or or or or or or or or or or	3   Ectopic pregnancy 5   Other (specify)    the underlying cause given in Part I.  26. Place of De  Other: 4   Nursing in the part I    28c. Injury at Work?  1   Yes   2x   No  n, street, factory, office  death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation.	23e. Did tobacc  1 Yes  24a. Was an autopsy performed at (Check only one)  1 Xyes 2 Clarification (Stree 26). Describe how in the constant of the cause of the ca	23d. Date of delive Month  2 No 3 Prob  24b. Were autoprior to cordeath? 1 Pros  6 Other (Specify njury occurred  ping with and Number or Rura (ale) 21 and Rura (ale) 6 and manner as st and place, and due to	Pry Day Year The cause of death? The cause of
after death.  Director: After this certificate has been signed by the attending physicien and Under the funeral director, page 2 should be detached for use as the burial-transit Under the funeral director.	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of Overlay  Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  as contributing to death but not resulting in the left of the l	3   Ectopic pregnancy 5   Other (specify)    the underlying cause given in Part I.  26. Place of De  Other: 4   Nursing I  work? 1   Yes 2   No  n, street, factory, office  death occurred at the time, date and plac or investigation, in my opinion, death occ  29c. License number	23e. Did tobac  1  Yes  24a. Was an autopsy performect. 1  Yes 2  ath (Check only one)  Home 5  Residence 28d. Describe how in the cause of the control of the cause of the control of the cause of the control of the cause of th	23d. Date of delive Month  2 No 3 Prob  24b. Were autopinor to cordeath? No 1 Prob  2 1 Prob  2 1 Prob  2 2 No 3 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 4 D. Were autopinor to cordeath? No 1 Prob  2 5 4 D. Were autopinor to cordeath? No 1 Prob  2 6 D. Were autopinor to cordeath? No 1 Prob  2 6 D. Were autopinor to cordeath? No 1 Prob  2 6 D. Were autopinor to cordeath? No 1 Prob  2 6 D. Were autopinor to cordeath? No 1 Prob  2 6 D. Were autopinor to cordeath? No 1 Prob  2 7 6 D. Were autopinor to cordeath? No 1 Prob  2 8 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D. Were autopinor to cordeath? No 1 Prob  2 9 6 D	eny Year  Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
After this certificate has been signed by the attending physicien and mineral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1	a. Asphyxia  Due to (or as a consequence of Overlay  Due to (or as a consequence of Overlay  Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  as contributing to death but not resulting in the left of the l	26. Place of De Other:  28. Place of De Other:  28. Injury at Work?  1 Yes 2 No.  29. License number  29. License number  29. License number  29. License number  29. License number	23e. Did tobac  1  Yes  24a. Was an autopsy performect. 1  Yes 2  ath (Check only one)  Home 5  Residence 28d. Describe how in the cause of the control of the cause of the control of the cause of the control of the cause of th	23d. Date of delive Month  2 No 3 Prob  24b. Were autoprior to cordeath? 1 Pros  6 Other (Specify njury occurred  ping with and Number or Rura (ale) 21 and Rura (ale) 6 and manner as st and place, and due to	eny Year  Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?

			1- State of Maryland /		rtment of He tificate of D		nd Ment		ene 201	] [;	03939
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Ruth T  Suit					ate of Death lonth	Day Y	90C	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  Howard County General Hospital		4b. City, Town, or Colum	bia			4c. County of Howa	rd	(0)
6.	Funeral Director	ì	5. Social Security Number  579-09-7161  Usual Residence of Decedent  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last b) 88	Yrs.	Months Days	If Under 24 Hours	Min. (A	ate of Birth fonth, Day, Y g. 27,	'ear)	Countr	ce (State or Foreign y) Virginia
	e Maryland la-f show	ctor	10a. State 10b. County 10c. City, To		cation ville						d. Inside City Limits 1 ☐ Yes 2 ( No
	th with the	ai Directo	10e. Street and Number  16201 Grist Mill Drive			855			. Citizen of Wha		
036	be filed within 72 hours after death with the Maryland lat Hygiane dother than "natural", or Itams 23e or 28e-f show event, I're Medical Evarting motal be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	li li	Vas Decedent of His Yes, specify Cubar ☐ Yes 2☑ No	spanic Origi n, Mexican, Specify:	in? (Specify Y Puerto Rican	es or No- , etc.)	14. Race - Black, Specify: V	White, et	c.
Baltimore, Maryland 21215-0036	within 72 hou ane than "nature than "nature	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give i lite. D	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most o	of working	16	Sb. Kind of Busin		vernment
land 2	e filed al Hygi other vent, I	To Be Co	17. Father's Name (First, Middle, Last)  Jesse Mustain Jennings					t, Middle, Ma	iden Sumame)		Criment
Mary	es 1 and 2 should be of Health and Mental flem 27 is marked or other traumatic ever				g Address (Street a				-		
more,	Pages 1 ar		20a Method of Disposition 20b Place	of Dispos	sition (Name of natory or other place Memorial	1	Date anuary 2004	26	c. Location - Cit	ty or Tow	
Balti	permit. Pages 1 Department of H Important: if ite any injury or ot		21. Signature of Funeral Service Licensee	Fr 50	Name and Addres ancis J. O Univers	Colli ity B	ns Fun 1vd. W	eral H	lome Inc	ing,	MD 20901
	Physician		23a. Pert1. Enter the disease, or complications that caused the leath. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	SWI	er the mode of dying	g, such as c	ardiac or res	oiratory arresi	t,	l l	Approximate interval Between Onset and Death
8760,	Medical Examiner  physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence or to the control of the control	ce of):	ffusi	0N:	S				
.O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)				23d. Date of Month		y Day Year
S, P	quires that in signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but not resulting  Diabytes Mellitus	g in the ur	nderlying cause give	n in Part I.		23e. Did toba 1 ☐ Yes			cause of death?
of Vital Record		Completed	Seizure Heart D	rise	asc			24a. Was an autopsy performe	prid ed? dea		sy findings available pletion of cause of
ion of Vita	nding Physician: Th th. : After this certificate s funeral director, pag	To Be	25. Was case referred to medical examiner?  1	Outpatien b. Time of Injury	28c. Injury Work	er: 4 🗆 Nur:	28d. I	5 Residen	ce 6 Other		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office			ocation (Stre City or Town,	et and Number State)	or Rural	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or in	n occurred at the tim vestigation, in my op	e, date and pinion, death	place, and d h occurred at	ue to the cau the time, date	ise(s) and mann e and place, and	er as sta d due to	ited. the cause(s)
	To the within 2 To the complet	¥	29b. Signature and title of certifier  Kathely Lynn-South	ws	29c. License	Oll		290	d. Date signed (	Month, D	OOY
			30. Name and address of person who completed cause of death (Item 23a	а) (Туре, М	Print) QS	010	old A	nnoge	olls ph	) E	- llicottict
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	Spark.			V		MA	121045

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	arylan		rtment of H tificate of L		Mental Hyg	iene 2 (	And the second	03940
			1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	Day	Vaar	3. Time of Death
	hysici: Medic/		Morton T. Swart	:h					January	20, 20	004ª	11:40 a M
}	iviedic Examin		4a. Facility Name (If not institution, give st	reet and number)			4b. City, Town, or	Location of Deat	h	4c. County	of Deeth	
			Holy Cross Hos	pital			Silver S	Spring		Montg	omery	I
F	uneral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Vearl	9. Birthp	place (State or Foreign
	rector		549-42-6009	M 2□F	83	Yrs.	Months Days	Hours Will.	Dec. 7,	1920		ifornia
Б			Usual Residence of Decedent									
ııylar	wow.		10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits 1 X Yes 2 ☐ No
e W	liffe	t S	California Alam	eda		0akla	ınd					
ë H	or 28	i e	10e. Street and Number				10f. Zip Code		1	0g. Citizen of		ntry?
Ť.	23a	Funeral Director	6850 Snake Road				94611			USA		
r dea	ema	ne r	11. Marital Status	<ol><li>Was Decedent Armed Forces?</li></ol>		S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	specify Yes or No- to Rican, etc.)		ce - Americ ick, White,	
a ale	2	by Fu	1 Never Married 2 Married	1 XYes 2 ☐ I If Yes, Give		10 1	☐ Yes 2⊠ No	Specify:		Specia	ּ ₩hit	e
5 m	ural I Ex	D D	3 XWidowed 4 Divorced	Year or Dates:	1940-							
72	"nat	Completed	15. Decedent's Educ (Specify onfy highest grade			(Give I	ent's Usual Occupa kind of work done o OO NOT use retired	during most of wo	rking	16b. Kind of B	usiness/in	dustry
Mithigan P	han Me Mi	d L	Elementary/Secondary (0-12)	College (1-4or 5	5+)		gineer	,		Engin	oorir	n or
peli led	P H	ပိ	17. Father's Name (First, Middle, Last)	4		111	gineer	18 Mother's Nar	me (First, Middle, M			<u> </u>
d be	94 o	Be	Harry S. Swa	rth					ifern Woo		, ,	
hould	mark	င္	19a. Informant's Name/Relationship (Typ			19b Mailin	n Address (Street a		ural Route Number		State Zir	Code)
d 2 s	7 ls trau		Christopher Swa						e, Silver			,
1 an	em 2 ther	1	20a. Method of Disposition	LLII/ BOII	20b. P	lace of Dispos	sition (Name of		Date	20c. Location	-	
ages of	= 3		1 ☐ Burial 2 🗷 Cremation 3 ☐ Re	moval from State			natory`or other plac	- Juli	uary 21	<b>A 1</b> arram	1	Vitaciaio
i. P.	rian Cuju		' 4 □ Donation 5 □ Other (Specify)  21. Signal of Funeral Service Licens	1.	net		tan Crema					Virginia
Deng	Important: If item 27 is marked other than "natural", or itema 23e or 28a-1 show any injury of other traumatic event, the Modical Examination and be multilled at once.		16 4	1		Fi	cancis J.	Collins	Funeral	Home :	Inc.	MD 20001
	12.	-	23a. Pent1. Enter the disease, or complic	ations that caused	the death						sprin	g, MD 20901 Approximate
			shock, or heart failure. List only one	e cause on each li	ne.			9, 00011 40 041014	o or roopmatory arre	301,		Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	Cardiop			rest					
	miner			Due to (or as								
		<u></u>	Sequentially list conditions,	Cardiac								
pet	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypoten		, .						
xecu	al-tra	Xar	that initiated events c. resulting in death) Last	Due to (or as		uence of):						
666	physician and s the burial-transit	ai		Acute B	lood	Loss						
icate	phys s the	edicai	0.									
certif	iding ise a	/We	IF FEMALE:	lc. If yes, outcome	of pregna	ncy				23d Da	ate of delive	any
eath	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)				onth	Day Year
the d	y the	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
The law requires that the death certificate be executed	certificate has been signed by the attending prector, page 2 should be detached for use as		Part II. Other significant conditions conf	ributing to death b	out not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use con	tribute to II	he cause of death?
uires	sign Id be	d by							1 □ Ye	s 2 No	3 🗌 Prot	oably 4 MUnknown
v requir	peer	Completed							24a. Was ar	n 24h	Were auto	ppsy findings available
16 a	s has	ם							autops	y ned?	prior to con death?	impletion of cause of
Ital	ficate r. pa		OF Was associated to modified						1 Yes 2		1 🗆 Yes	2 No
VII	is certificate has director, page 2	o Be	25. Was case referred to medical examiner?  1 Yes 2 2No	ospital: 1 🖾 Inpatie		50/O	Othe	ar	ath (Check only on			
2 £	rthis raldi	H	27. Manner of Death	28a. Date of Inju	iry	ER/Outpatient 28b. Time of	28c. Injury	4 □ Nursing F	lome 5 Reside			(y)
oding 4	Afte	tion	1 Natural 5 Pending	(Month, Da	y Year)	Injury	Work	<br Yes 2 □ No		,,		
r Atten	ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of Inj	jury - Al ho	ome, farm, stre	et, factory, office		28f. Location (St	reet and Numi	ber or Rura	al Route Number,
S ion	Dire in b	erti	4 ☐ Homicide determined	building, et	c. (Specify	v)	7,		City or Town			
spita	filled		29a. Certifier 1 X Certifying Phys	ician: To the best	of my kno	wledge, death	occurred at the tim	ne, date and place	and due to the ca	use(s) and m	anner as s	tated
Ho:	e Fur	edical	(Check only 2 Medical Examin	er: On the basis o and manner sta	f examina	tion and/or inv	restigation, in my or	pinion, death occu	urred at the time, da	ate and place,	and due to	o the cause(s)
To the Hospital or Attending Physician:	To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier				29c. License	number	25	9d. Date signe	d (Month)	Day, Year)
h - 3	الل						1	614	7		106	DCL
10	170		30. Name and address of person who cor	noleted cause of o	death (Item	1 23a) (Type I	Print)	V17	/	1	1	U T
			Dr. Nasreen Kango					Takomo	Park, M	0 2001	)	,
Ŷ	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa		1203	, rakuma	LAIR, MI	40714	-	
	Registr		IAN 22 200	4 Aleps	war	fool	popular					

			1 - For State Registrar	Stat	te of M	arylan				ealth a Death	and M	ental Hy	giene Reg. No.	200		03941
			1. Decedent's Name (First, Middle,	Last)								2. Date of De Month	ath Day	Y	9 <b>0</b> r	3. Time of Death
	Physicia		Shirley M.	Sny	der							January	7 16		<u>)</u> 4	10:18 AM
i	/Medic Examin		4a. Fecility Name (If not institution,	jive street ar	nd number,	)		4b. City	Town, or	Location of	of Death		4c.	County of I	Deeth	
			Montgomery Gen	eral H	lospit	:a1			ney				Mo	ntgor	nery	<b>J</b>
	Funeral	-	5. Social Security Number 6	. Sex 1 □ M 2 d	7. A	ge (In yrs. I	ast birthday)	If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Coun	
	Director		382-22-4524	1 L M 24	ar	76	Yrs.					Mar. 8	, 192	27 M	ich	Lgan
	D .		Usual Residence of Decedent  10a. State 10b. County		-	10c. City	/. Town or Lo	ocation							1	0d. Inside City Limits
	anyla eho	2		m A 7'37		Cat	ithers	huro								1 Yes 2 No
	Ne M	Directo	Maryland Montgo  10e. Street and Number	nery		04.	Leners		o Code				10a. Citiz	zen of Wha	at Coun	itry?
	with t	ā	101 Odend Hal	A 220 10 11 C					0877					ed S		
	hours after death with the Maryland tural; or Iteme 23a or 28a-f ehow al Examinat must be notified at	Funerai	101 Oderid nai			t Ever in U.	S. 13.				gin? (Spe	ecify Yes or No		14. Race -	Americ	an Indian,
	iten de	Š	1 ☐ Never Married 2 ☐ Marrie	Arm	ed Forces	? !No						cify Yes or No Rican, etc.)		Black,	White,	etc.
50	Irs af	by	3 Widowed 4 ☐ Divorced	If Y	es, Give ir or Dates:			1 🗆 Yes	2 <b>♠</b> No	Specify:				Specify:	Wh:	ite
21215-003b	2 hou		15. Decedent's	Education	lada di		16a. Dece	dent's Usu	al Occup	ation	t of worki	00	16b. Kir	nd of Busin	ess/Ind	dustry
212	hin 7	pie	(Specify only highest Elementary/Secondary (0-12)		lege (1-4or	5+)			ise retired	during mos	I OF HOTA	, ig				
7	d with	Completed	12				Homen	naker						Home	:	
	be filed within 72 hours after death with the Marylan it all tygiene. Id other than "netural; or itema 23a or 28a-f show other than "netural; or itema 25a or 28a-f show event, it a Medical Examinat must be notified at	Be	17. Father's Name (First, Middle, L.	ist)								(First, Middle				
Maryland	Venta Wenta	To	Eugene N. Hanna	ih, Sr	•							ene E.				
a	2 should be filed within 72 h and Mental Hygiene. Is marked other than "netu raumatic event, Its Medica		19a. Informant's Name/Relationshi	p (Type, Prir	nt)			•				I Route Numb	-			Code)
2	and 2 ealth m 27 i		Mark R. Snyde:	c / So	n					ive		ne, Ore				
Baltimore,	- I = =	١.,	20a. Method of Disposition  1 Burial 2 Cremation	1 □Велоча	I from State		lace of Dispo emetery, cre	osition (Na matory or	me of other plac	(8)	Jan.	19	20c. Lo	cation - Cit	y or To	own, Stete
Ĕ	Pages nent of ant: If its		4 □Donation 5 □ Other (Sp.	ecify)		Nor	beck N			Park	2004	17,	01ne	y, Ma	ıry1	and
a	portr portr y inj		21. Signature of Funeral Service L	censee						ss of Facili	DC	Vol Fur				
m	89 = 8		1) Jung C	M	1							Gaith		urg,	MD	20877
			23a. Part1. Enter the dispase, or o shock, arheart failure. List o tmmediete Cause (Final	omplications nly one caus			h. Do not en		de of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a		s a conseq		2 11							+	140011
	Examiner						CTZU	6	201	J 6	DI	16A1	6			IOYEARS
à		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b		s a conseq										
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events													
Ć,	exec n an ial-tr	Exa	resulting in death) Last	Ü	Due to (or a	s a conseq	uence of):			-						
760,	ite be iysicia he bur	cai		d												
9	ificat g ph) as th															
ŏ	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant			e of pregna		⊒Ectopic	areananci	,				23d. Date o		•
$\mathbf{m}$	death e atte d for	icia	in the past 12 months?	4	Pregnant	at time of d		Other (						Month	1	Day Year
o.	that the de led by the a detached f	hys	9 Unknown	91_	Unknown											
S, D	es tha igned be det	by P	Part II. Other significant condition	15 contributir	ng to death	but not res	ulting in the u	underlying	cause giv	en in Part	I.		,			he cause of death?
ğ	quire on sig uld b											1 🗗	Yes 21	□No 3	☐ Prob	oably 4 Unknown
00	aw requir as been s 2 should	Completed										24a. Was		24b. Wa	re auto	ppsy findings available impletion of cause of
Re	0 - 0	E										perf	ormed? 2 ☑ No	dea	ith?	2 1 No
Vital Record	ician: Th certificate rector, pag	0	25. Was case referred to medical							26. Plac	e of Deat	h (Check only				
	Physician: this certificatal director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospita	li: 1 🗷 Inpa	tient 2	ER/Outpatie	nt 3 🗆 [	Oth	er: 4 🗆 N	ursing Ho	me 5 Res	idence	5 Other	(Specif	<i>(y)</i>
of	<u>a</u> = <u>e</u>		27. Manner of Death		. Date of In	jury Da <i>y Year)</i>	28b. Time o	of	28c. Injur	y at		28d. Describe	how injur	y occurred		
ion	Attending P r death.	atio	1 Actural 5 Pending 2 Accident investig		(	, ,	,,	М		Yes 2	]No					
Division	Atte	ific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi			njury - At h etc. (Speci	ome, farm, st	treet, facto	ry, office			28f. Location	Street an	d Number	or Rura	al Route Number,
ā	tal or s afte al Dir ed in	Certification:				, - , - , - , - , - , - , - , - , - , -	•									
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai		xaminer: O		of examina						and due to the red at the time				
	To the within To the comple	Me	29b. Signature and title of certifier					2	9c. Licens	se number			29d. Da	e signed (	Month,	Dey, Year)
	F ≯ F ŏ		DA 1. 2	nn.	nop				02	363	0		JA	2001	, ,	6,2004
10			30. Name and address of person			f death (Ite	m 23a) (Tyne	, Print)								
			Frield J. MA'16				eder.		KA	4213	6.	· their	111.	MA	26	8 77
	St	ate	31. Date filed (Month, Day, Year)			strar's Sign			,							
	Regist		JAN 2 0	2004	Ser	ena	9	de	ak							

			Ficase	State of Manuar			-	_	
			for State	State of Marylan	Certificate			2000	03942
			Registrar  1. Decedent's Name (First, Middle, La	net)	Certificate		Reg. No. 2. Date of Death	¥o.	3. Time of Death
	Physici	an		st Smith			Month E	14 2004	1545 M
	/Medic				ENTER 4b. City, To		January	4c. County of Death	1242
	Examin	er	4a. Facility Name (If not institution, giv						
			5. Social Security Number 6. S	Sex 7. Age (In yrs.			B. Date of Birth	MONTGO	
	Funeral			ISM 2□ F	Yrs. Months	Days Hours Min.	(Month, Day, Yea		ace (State or Foreign try)
	Director		577-09-5015 Usuel Residence of Decedent	84			ct.1,1919	Washi	ngton,DC
	land ow		10a. State 10b. County	10c. Cit	y, Town or Location			10	d. Inside City Limits
	Mary 1 sh	हं .	Maryland Montgon	nerv	Silver S	ring			1 ☐ Yes 2 反 No
	28e	Director	10e. Street and Number	iciy	10f. Zip C		10g. (	Citizen of What Coun	try?
	3a o	0	15011 Haglamana (	lount		20906		IIC A	
	ms 2	Funerai	15011 Haslemere (	12. Was Decedent Ever in U.	S. 13. Was Decede	nt of Hispanic Origin? (Spec Cuban, Mexican, Puerto R	ify Yes or No-	IJSA 14. Race - America	
(0	r Ite	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1			ican, etc.)	Black, White, e	etc.
ဗ္ဗ	al', o	Š	3 ☑ Widowed 4 ☐ Divorced	Year or Dates: WWI	I IL Yes 20	No Specify:		Specify: Whi	te
O O	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23s or 28e-f show ent, the Mudical Examene must be notified at	Completed	15. Decedent's E (Specify only highest gro	ducation	16a. Decedent's Usual	Decupation	16b.	Kind of Business/Ind	ustry
2	thin e	Pd	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	done during most of working retired)			
7	od wi	ő	12		Administrat			<u>Federal Go</u>	vernment
2	a la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last	)		18. Mother's Name (	(First, Middle, Maid	en Sumame)	
ā	Ment Ment arked	ပ	John A. Smith			Jessie My	ers		
Maryland 21215-0036	2 sho and Is m		19a. Informant's Name/Relationship (	Туре, Print)	19b. Mailing Address (	Street and Number or Rural	Route Number, City	y or Town, State, Zip	Code)
≥ .	and ealth n 27 ner tr		John A. Smith	Son	114 Glenco				nia 19082
ore	Tite T		20a. Method of Disposition 1 弦Burial 2 □ Cremation 3 回	Removal from State Ca +	Place of Disposition (Name Remetery, crematory or oth e of Heaven	of Da er place)	20c.	Location - City or To	wn, State
<u>Ē</u>	Pag ant:		'4 ☐ Donation 5 ☐ Other (Speci	(y)	Cemetery	Jan.19	9,2004 Si	lver Spri	ng,MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show among vijurg or other treumatic event, the Madical Examinat must be notified at anone.		21. Signature of Funeral Service Lice	nsee	22. Name and	Address of Facility  I Colline F	uneral Ho	ome Inc	
Ш_	205 2		Maries 9	3 March	500 Uni	J. Collins F versity Blvd.	,W.,Silve	er Spring,	MD 20901
			23a. Part1. Anter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	h. Do not enter the mode	of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a ASPIRATIO				t	Onset and Death
ſ	/Medical		resulting in death)	Due to (or as a conseq				-	
	Examiner		Sequentially list conditions	b. DYSPHAGIA	<b>t</b>			I	)AYS
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
	ecute ind trans	Examiner	that initiated events resulting in death) Last	· CEREBROVA		CIDENT		l	DAYS
,092	ate be executed hysician and he burial-transit		resulting in double Last	Due to (or as a consequence	uence or):				(
876	ate b hysic the b	lical	•	_ d					
Box 68	ing p	Mec	IF FEMALE:						
ဓ္ဏ	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3 □Ectopic pre			23d. Date of deliver Month	ry Day Year
	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5 🗆 Other (spec	ify)	·		,
P.O.	w requires that the death certificat been signed by the attending phy should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying car	se given in Part I	23e Did tobacc	o use contribute to the	e cause of death?
Š,	ires ti signe	ğ	ALZHEIMER	•		50 g. (61 ii ) a. (1.			ably 4 □Unknown
50	requi	sted	AUTHUNCE	DIDENSE					
ခ	e law	Ę.					24a. Was an autopsy performed?	prior to con	ssy findings available apletion of cause of
=	The pag	Sor					1 ☐ Yes 2 🗷		2 No
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	113-1		26. Place of Death	(Check only one)		
=	hysi this c	은	1 ☐ Yes 2 No	1	ER/Outpatient 3 DOA	<del></del>		6 □Other (Specify	)
Division of Vital Records,	ing P	Certification;	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		Work?	3d. Describe how in	llury occurred	
sio	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not t		M	1 Yes 2 No	26		C. t. H. arts
i <u>≅</u>	or At fter c jirec in by	ŧ	4 Homicide determined			office 20	City or Town, Sta	and Number or Rural ate)	Houle Number,
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		202 Cartifier 15 Continue 2	hydician: To the heat of my line	waledge dooth a	the time date and slave ==	ad due to the access	(c) and manner	atod
	Hos 24 hc Funi	edical		hysician: To the best of my kno miner: On the basis of examina and manner stated.					
	To the Hospital within 24 hours a To the Funerel Completely filled	Med	29b. Signature and title of certifier	and manner stated.	29c.	icense number	29d. [	Date signed (Month, L	Day, Year)
				ATT- 12	Pallyrica	DUZOUL-	10	1) A-0 I	4 7 mel
6	341		30. Name and address of person who	ATTENDING	7 77771C404	i tuju	<u> </u>	المحاربين	1 DOL
			GRACE BROOKE 1	+UFFMAN M,	D 18100 CLA	icense number D42046 ESCHOOLRI	AD SAND	4 Spenie 1	MARULAND
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature /	2 1100- 14	יווע ביווים	7 - 1 - 1 - 1	יאווייייייייייייייייייייייייייייייייייי
	Di-A		IAM 2 0 2	nns beneva	D 100	eks			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jan. 17, 2004 SUSAN SOPOURN 6:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Gaithersburg

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year) Montgomery 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 1 F 60 Director 577-58-0146 Nov.12, 1943 Wash. D.C Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 N Yes 2 No Director Md. Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9751 Brassie Way 20886 U.S.A. Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International Assoc.of Elementary/Secondary (0-12) Cottege (1-4or 5+) Fire Fighters Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emery de Hartman Marion Morris ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa E. Sopourn/Daughter 153 Mesa Circle, Lafayette, Colorado 80026 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If its
eny injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jan 20,2004 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory Alex., Virginia 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave. N washington, D.C. 2000/ 23a. Part 1. Stier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease or condition resulting in death)

Devol Funer 2222 Wisconsin Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, 21. Signature of Euneral Service License Approximate Interval Between Onset and Death INFARCTION Physician MINUTE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) P.O. Box 68760. ding physician Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of detivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) ed by the a detached for Yes 2 No 9 Unknown 9 Unknown been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 ☐ Yes 2 🕽 👀 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) : After this funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation thin 24 hours after death.

the Funeral Director: Af
impletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Daire Rockville CENTER MEDICAL SROUR N 21 31. Date filed (Month, 32. Registrar's Signature State Registrar

			1 - For State Registrar	St	ate of M	arylan		artmen rtificat			and M		Reg. No.	04	03944
	Physicia		1. Decedent's Name (First, Mic	dle, Last)								2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic			oinder	Sol							Januar	-	004	7:35 P. <sup>™</sup>
	Examin	er	4a. Facility Name (If not institut	•				_		Location of	of Death		4c. County		
2.			Montgomery G  5. Social Security Number	6. Sex			ast birthday)	If Under	ney	If Under:	24 Hrs.	R Date of Rid	Mont		
	Funeral Director		209–36–2108	1 ☐ M		90 (III yis. 1 84	• •	Months		Hours	Min.	8. Date of Bin (Month, Da July 19	7 (Year) 7 1919	Out	place (State or Foreign htry)
			Usual Residence of Decedent							1		July 1.	1010	.vew	TOLK
	yland		10a. State 10b. Cour	•			, Town or Lo eaton	cation							10d. Inside City Limits
	e-1-s	Funeral Director	Maryland   Mont	gomery		AATIC	acon								1 ∑Yes 2 ☐ No
	라 58 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Oire	10e. Street and Number					10f. Zip					10g. Citizen of W	hat Cou	ntry?
	23e	ral	13104 Matey R				,		0906				United		
	e La	nu	11. Marital Status	A	Vas Decedent Irmed Forces?		S. 13.	Was Deced f Yes, spec	lent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		- Americk, White,	can Indian, etc.
36	s afte	by Fi	1 ☐ Never Married 2 🔯 M 3 ☐ Widowed 4 ☐ Divorc	. If	☐ Yes 2 📆 Yes, Give	No		1 ☐ Yes	2 XNo	Specify:			Specify:	Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than *naturel; or tems 23a or 28a-f show int, the Madical Examinar must be notified at			ent's Education	ear or Dates:		16a. Dece	ient's Lisus	I Occupa	ition			16b. Kind of Bu	siness/Ir	dustry
5	in 72	Completed	(Specify only high	est grade con	npleted)	- \	(Give	kind of wor DO NOT us	rk done d e retired)	uring most	of workir	ng .	TOD. TAILS OF BO	)III 0 3 GE 111	oustry
212	iene.	Шo	Elementary/Secondary (0-12 12		College (1-4or	5+)	Homer	naker					Own H	ome	
힏	m - 0 5	Be C	17. Father's Name (First, Midd.							18. Mothe			Maiden Sumame		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tha M	To	Nathan Bookb						(2)	Ida			ookbinde		
	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 271s marked any injury or other traumatic events.		19a. Informant's Name/Relation  Jerry Alan So					-				on, MD	er, City or Town, S 20906	state, Zip	o Code)
w	Pages 1 and the control of the contr		20a. Method of Disposition 1 □ Burial 2 □ Crematio	n 3 □Remov	val from State	20b. P	lace of Dispo emetary, crer D - Wasi	sition (Nan natory or o	ne of ther place	sitv	o Janu	ary 15	20c. Location - 0	Dity or To	own, State
	artmen ortent: injury		' 4 ☑ Donation 5 ☐ Other  21. Signature of Funeral Service		7 .	Me	edical	Cent	er d Addres	s of Facilit	20 v	04	Washin	ton	, D.C.
m m	permit. Departr Importe any inji		Blutze	ic	and	2		Colum P.O.	bia 1 Box	Mortu 58007	ary Was	Service hington	es,Inc	<u> 2003</u>	7
#6	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, sock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury)	st only one cal	use on each I	a consequ	uence of):	l:	Inf	anc	ten				Inierval Between Onset and Death
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edicai Examin	that initiated events resulting in death) Last	d	Due to (or as	a consequ	uence of):								
.O. Box	at the death certifin by the attending I tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	1 4	yes, outcome □Live birth □Pregnant a □Unknown	2 Fetel	death 3	Ectopic pr Other (sp					23d. Date Mon		ery Day Year
ds, p	ires that signed t	by	Part II. Other significant cond	tions contribu	ting to death t	out not resu	A .	nderlying c	-1-	n in Part I.				bute to tl 3 □ Prot	he cause of death?
Ö	w requir been si should	etec	Dieli	P . K	1.00,	Lus									
Œ .	9 4	Completed	121200	ag i	jeu	100)						24a. Was autor perfo 1 ☐ Yes •	sy pr smed2 de	rior to co eath?	opsy findings available impletion of cause of
	icien: Th certificate rector, pag	Be C	25. Was case referred to medi	al						26. Place	of Death	(Check only o			2010
	% .∞ <del>\</del> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ToE	examiner? 1 🗆 Yes 2 No	Hospit	tal: Unpati	ent 2 🗆 I	ER/Outpatien	t 3 DC	A Othe	r: 4 □ Nu	rsing Hon	ne 5 🗆 Resid	dence 6 Othe	r (Specif	(y)
0	ding Ph h. After th funeral		27 Menner of Death  1 SNatural 5 ☐ Pen		Ba. Date of Inju	ıry ıy Yə <i>ar</i> )	28b. Time of Injury	2	8c. injury Work	at ?	2	8d. Describe I	now injury occurre	d	
<u>Ö</u>	Attending ir death. ector: After by the fune	atic	2 ☐ Accident inve	stigation				М		′es 2 🗆 l	No				
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 28	le. Place of In building, et	jury - At ho lc. <i>(Specif</i> y	me, farm, str	eet, factory	, office		2	8f. Location (S City or Tox	Street and Numbe vn, State)	r or Rura	al Route Number,
	urs a urs a aral D		00.00.415								40				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical	29a. Certifier (Check only one)	al Examiner: (	n: To the best On the basis o and manner st	of examinat	wieage, death ion and/or inv	occurred restigation,	at the tim in my op	e, date and inion, deal	piace, a h occurre	nd due to the	cause(s) and man date and place, a	ner as s nd due to	tated. o the cause(s)
•	To the To the To the Complet	W	29b. Signature and title of certification	www.	J.	Nin	la_	. I		528			29d. Date signed		Day, Year) +, 2004
	1		30. Name and address of person	on who comple	ted cause of c		23a) (Туре. W-lvк	Print)	nd	井113	, 8	n lver	spring.	, Ma	120901
	Sta Registr		31. Date filed (Month, Day, Ye. JAN 2	Ž 2004		rar's Signal	ture &	Spi	uls				spring,		

			For State	State of Ma		d / Depa		lealth a	and Mer	ntal Hygi	ene		1391,5
			Registrar				tineate or	Deain		Date of Death	9.110.	3 14	3. Time of Death
٠.	Physici	an	Decedent's Name (First, Middle, Last)							Month	Day Y	eer	
	/Medic		Catherine Whitak		<u> </u>				Ja	nuary	12, 2004		11:00 a M
	Examir		4a. Fecility Name (If not institution, give s				4b. City, Town, o	r Location	of Death		4c. County of	Death	
			4601 North Park Av	enue #505	5		Chevy C	hase			Montgo	omer	ТУ
	Funeral Director		334.12.0703	7. Ago	9 (In yrs. la 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. Ap	Date of Birth (Month, Day, ril 14	Yeer) , 1924	Birthp Cour [11i	nlece (Stete or Foreign ntry) Lnois
	pu ,		Usuel Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					1	0d. Inside City Limits
	aryla ahov	ڀ	MD Montgomer	v		evy Ch							1 ☐ Yes XXNo
	W T	cto		J									1 103 22210
	# 12 B	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	at Cour	ntry?
	h wi	<u>a</u>	4601 North Park A	venue #50	)5		20815				U.S.A.	•	
	deat deat	Jer	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. \	Was Decedent of H	lispanic Ori	igin? (Specify	Yes or No-	14. Race -		
10	ife a	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give	No	1				ari, etc.)	Black,		
ဗ္ဗ	o','s	by Funerai	3 ☐ Widowed 4 XX ivorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:	:		Specify:	wnı	te
ڄ آ	thur attur	Completed	15. Decedent's Educ			16a. Deced	ient's Usual Occup	ation		1	6b. Kind of Busir	ness/in	dustry
5	n 7	jet	(Specify only highest grade			(Give	kind of work done DO NOT use retired	during mos d)	st of working				~
7	than the	E	Elementary/Secondary (0-12)	College (1-4or 5	)+)	Se	cretary				Administ	rat	ion
2	ther int,	ŭ	17. Father's Name (First, Middle, Last)	•			323333	18. Mothe	er's Nam <i>e (F</i>		aiden Sumame)	-146	.1011
E	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Hems 23e or 28e-f show artic event, the Medical Exacinar must be rotilled at	Be	Garfield Whi	taker						e Leav			
₹	Mer Mer Marke	ို											
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show my injury or other traumatic event, the Medical Examination must be notified at ance.		19a. Informant's Name/Relationship (Type Scott Siegil/ Son				ng Address <i>(Street</i> ridith C						
2	and saith n 27					The Same			1 5000				
Š	of H		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	amazzal from State	20b. Pl	ace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date		Oc. Location - Ci	ty or To	own, Stete
Ĕ	Page and Sold		1 ☐ Burial 2 ☑ Cremation 3 ☐ Pi	emoval from State	Mt.	Comfo	rt Crema	tory 1	L/16/20	004 A	lexandri	a,	VA
=	artmartmorts orts		21. Signature of Funeral Service License	90	ė.		. Name and Addre				ler's So	ns,	Inc.
ã	Deparit		12 - 5	-			30 Wisco					_	
á	本		23a Part1 Enter the disease or complia	cations that caused	the death	Do not ent	er the mode of dvir	ng such as	cardiac or re	spiratory arre	st		Approximate
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each lir	10.	. 50 1101 0111	or the mode or dyn	.g, 00011 a0	, , , , , , , , , , , , , , , , , , , ,	ophatory and	J.,		Interval Between Onset and Death
18	Physician	1	Immediate Cause (Final disease or condition	Cardia	Dys	rhythm	ia						
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):							
	Examiner		Sequentially list conditions	Coronai	ry Ar	tery D	isease					5	years
	AILME	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):							
	uted d ansil	Ē	Cause (Disease or injury that initiated events	Hyperte	ensio	n						1	.5 years
<u>_</u>	exec n an ial-tr	Examiner	resulting in death) Last	Due to (or as	a consequ	ence of):							
760,	ite be executed sysician and ne burial-transit	cai		ı									
687	phy s the											1	
×	death certifical e attending phy ed for use as th	/We	IF FEMALE:	3c. If yes, outcome	of pregnar	ncv					23d, Date of	f dalise	200
Вох	ath atten	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetel	death 3	Ectopic pregnancy	У			Month		Day Year
0	e de the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or de	iatn 5	Other (specify) _		<u> </u>				
<u>o</u> .	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med								00 Div.	_		
-	gnec oe d	þ	Part II. Other significant conditions con	itributing to death b	ut not resu	itting in the ui	nderlying cause giv	ren in Part I	l.				ne cause of death?
5	quire an si	eq	Breast Cancer							1 🗆 Yes	2 <b>2X</b> No 3	_ Prob	ably 4 Unknown
Vital Records	w re	Completed								24a. Was an	24b. We	re auto	psy findings available
Re	ha: ge 2	E								autopsy perform	ed? dea	th?	mpletion of cause of
a	r. Ti									1 ☐ Yes 2		Yes	2 No
Ħ	Physician: r this certificatal director, i	Be	25. Was case referred to medical examiner?	locatal:			104			heck only one			
of	hysi his c	P	1 165 2 100	lospital:		ER/Outpatien	t 3 DOA	4 □ No			ce 6 Other	(Specif)	y)
D C	ng P fter t nera	ü	27. Manner of Death 1 △Naturel 5 ☐ Pending	28a. Date of Inju (Month, Day	ry y Yeer)	28b. Time of Injury	28c. Injur Wor	y at rk?	28d	. Describe how	v injury occurred		
Division	Attending red death.	ati	2 Accident investigation				M 1 🗆	Yes 2	No				
<u>×</u>	Atte	ill lo	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At ho	me, farm, str	eet, factory, office		28f.	Location (Stre City or Town,	et and Number	or Rura	l Route Number,
	afte afte din	Certification;		Duilding, on	o. (Opcony	,				Only or rown,	Diato)		
	To the Hospital or Attending Physician: The lav Wribin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phys	sician: To the best	of my knov	wledge, death	occurred at the tir	me, date ar	nd place, and	due to the car	use(s) and mann	er as st	tated.
	24 t 24 t Fu etety	edicai	(Check only 2 Medicel Examir one)	ner: On the basis of and manner sta		ion and/or in	vestigation, in my o	pinion, dea	ath occurred a	at the time, da	e and place, and	due to	the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	A	_	4	29c. Licens	e number		29	d. Date signed (/	Month,	Dey, Year)
	- 3 - 8		15	(0)	, 0,	MO	DC 58	324			anuary		
7	12		, I Luca	7 00	~ /	VII							
			30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type,	Print)	on D	C 200	137			
			Bryan Arling, MD.,				wasningt	.оп р.					
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure 4	Spark	1					
	Regist	rar	JAN 2 0 200	14 Arms		1	popular						

			1 - For State Registrar	Sta	te of N	Marylan	d / Depa <i>Cei</i>	artmer <i>tifica</i> :	nt of H te of L	ealth a Death	and M	ental Hy	giene Reg. No	200	i.	03946
			1. Decedent's Name (First, Midd	e, Last)								2. Date of De		٧-		3. Time of Death
	Physici		Carlton R. S	ickles								Month Januar	ry 1			7:26A M
	/Medic Examin		4a. Facility Name (If not institution	n, give street a	und numbe	or)		4b. City	, Town, or	Location of	of Death		40	. County of D	eath	
			6603 Old Sta	ge Road	l			Nor	th Be	ethes	da		1	Montgo	mer	у
	Funeral		5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di June ]	rth av. Year	9.	Birthpl	ace (State or Foreign
16	Director		579-18-2056	1 X M 2		82	Yrs.					June 1	5,	1921 C	onn	ecticut
	pu k		Usual Residence of Decedent  10a, State 10b, County			10c Cit	y, Town or Lo	cation							10	d. Inside City Limits
	aho	5	,													1 ☐ Yes 2X No
	Ne M	ecto	Maryland Mont	gomery		Nor	th Bet		a p Code				10- 0	tizen of What	Cover	
	with t	ā						1								
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ahow the Madical Examiner must be notified a	Completed by Funeral Director	6603 Old Stag		s Decede	nt Ever in U.	S 131		852	snanic ∩ri	ain? /Sner	cify Yes or No		ted St		
	iten d	Į.	1 Never Married 2 Mar	Arr	ned Force	s? Lian	ld '	Yes, spe	cify Cuba	n, Mexican	i, Puerto P	Rican, etc.)		Black, V		
336	urs at	by	3 ☐ Widowed 4 ☐ Divorced	1111	Yes 2 [ es, Give ar or Date:	™ War ™ Kore		t □ Yes	2 <b>∑</b> No	Specify:				Specify:	Whi	te
21215-0036	2 hou	led	15. Deceder	nt's Education		ROIC	16a. Dece	ient's Usu	al Occupa	ation			16b. K	and of Busine		
215	nin 7	pie	(Specify only higher Elementary/Secondary (0-12)		llege (1-4c	or 5+)	life.	DO NOT	onk done d ise retired,	luring mos )	t of workin	g	Per	nsion	and	Health
21	d with	EO	Eldinarially contains (or 12)		5+		La	wyer					Adı	minist	rat	ion
פ	otho Vent,	Bec	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
<u>a</u>	Aenta Aenta rked	To E	Carl W. Sickl	es						Lou	ise E	E. Tore	e11o			
Maryland	and !		19a. Informant's Name/Relations	ship <i>(Type, Pri</i>	int)		19b. Mailir	g Addres	s (Street a	and Numbe	er or Rural	Route Numb	er, City	or Town, Stat	e, Zip	Code)
Z,	and 2 paith n 27 i		Jacqueline Eig	Sick1	es/Wi	fe	6603	01d	Stage	e Roa	d, No	orth Be	ethe	sda, M	ary	land 20852
ore	T T T T		20a. Method of Disposition 1X Burial 2 □ Cremation	3 Demove	l from Sta	20b. P	Place of Disponentery, cremotery,	sition (Na natory or	me of other place	<sub>9</sub> ) J	anuar	cy 21,	20c. L	ocation - City	or Tov	vn, State
Ĕ	Page Int: H		`4 □Donation 5 □ Other (S		ii ii Oiii Sta	Geo	orge Wa Cemet	ishin erv	gton	,	004	,	Ade	lphi,	Mar	yland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow among young to other traumatic event, the Madical Examiner must be notified at anone.		21. Signature of Foreral Service	Ligensee			22	. Name a	nd Addres	s of Facilit	y Robe	ert A.	Pum	phrey	Fun	eral Home/
m	8258		Muile	. Per	7.	MOC	)803 B	thes	da,_l	levy Maryl	and_	20814-	-350	l wis	COn	sin Avenue
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications only one caus	s tha caus	ed the deat	h. Do not ent	er the mo	of dying	g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Conge	estive	Heart	Fai	lure							Onset and Death Veeks
	/Medical		resulting in death)	a	Due to (or a	as a conseq	uence of):									_
	Examiner		Sequentially list conditions,	b	Card:	Lomyop	athy									lears
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ic) of eac	as à conseq	uanca of):								П	
	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C											1	
90,	e exe ian a urial-	Ĕ	resulting in dealing cast	,	Due to (or a	as a conseq	uence of):									
8760,	ate b hysic the b	dical		d											-	
9	ing p	Med	IF FEMALE:												!	
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	10	Live birth	ne of pregna 2 □ Feta	Ideath 3□		regnancy				- 1	23d. Date of Month		y Day Year
0	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		]Pregnant ]Unknown	at time of d	eath 5∟	Other (s	pecify)							, , , , , , ,
<u>P</u> .	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as	Physician/Me	Part II. Other significant conditi	ons contributir	na to death	hut not rec	ulting in the u	nderh/ing	natice one	n in Part I		23a Did	obacco	use contribut	e to the	cause of death?
JS,	signe d be c	þ	Hyperlipidemi		-		-		_							bly 4 Dunknown
000	w require been si should I	etec						<u>r ——                                   </u>						30110		
Records,	elaw hast je 2 s	Completed	s/p Pacemaker	Place	ment							24a. Was	psy	prior	to com	sy findings available pletion of cause of
A IE	: The	ပိ										1 ☐ Yes	ormed? 2 1 No	death 1 🗆 \		2□ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospita	1.				100			(Check only				
of	Physical this call direction	2	1X Yes 2 No		1 🗀 Inpa	- 1	ER/Outpatien					e 5 X Resi			pecify)	
n	After uner	lon	27. Manner of Death 1 X Natural 5 ☐ Pendi	ng	. Date of Ir (Month, I	Day Year)	28b. Time of Injury		28c. Injury Work	?		8d. Describe	how inju	ry occurred		
Division	Attanding r death. actor: After by the fune	Certification;	2 Accident Invest 3 Suicide 6 Could	not be	Discont	laine. At he		M		/es 2 □ !		Of Leasting (	C44	- d & l		D N
Σ	l or Attano after deatl Diractor: in by the	ırtif	4 ☐ Homicide determ	nined 289	building,	etc. (Specify	ome, larm, str y)	eet, factor	у, опісе		2	City or To			Murai	Route Number,
	pital ours aral l	2	202 Conting 1A Continu	ag Physician	T- 15- 5-	-1 -1	viladas disable			- 4-1-	1 1	11				
	Hos 24 hc Fun.	Medical	29a. Certifier 1 <sup>th</sup> Certifyi (Check only 2 Medical	ng Physician: Examiner: Or	no the basis the basis d manner	of examina	tion and/or in	estigation	n, in my op	e, date and inion, deal	u piace, ai th occurre	d at the time,	date and	and manner diplace, and	as sta due to	ted. the cause(s)
	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely litled in by the funeral director, page	Mec	29b. Signature and title of certifie		- manifier	Jiaidu.		29	c. License	number			29d. Da	te signed (M	onth, D	ay, Year)
	F3F8		SA	1	0	ô /	uD		00947					ary 19		
-	1041		20 Name and address of	Who 2277						-			aiiu	ary 19	, 4	
			30. Name and address of person Eugene P. Libi				onnect		Δτιοπ	110 4	£606	Kanai	nata	n MD	20	895
	Sta	te				strar's Signa		100	A		000,	Kensi	ngco	ii, MD		עלטי
	Sta Registr		31. Date liled (Month, Day, Year JAN 2	2004		necessar	19	A.	200 pl	10						

			1 - For State Registrar	State of M	aryland / D	epa Cen	rtment tificate	of H	ealth a Death	and M		giene Reg. No		erdinal	0394	7
	Physic /Medi	cal	Decedent's Name (First, Middle, Last)     Lottie Shock     4a. Fecility Name (If not institution, give second)	street and number)			4h City 1	Town or	Location o		2. Date of De Month  1-20-26	Da 004	y Ye		3. Time of Death 8:03 A.	М
	Examir	ner	Green Acre Assiste	ed Living			Silve	er Sj	ring		-	M	ontgon			
	Funeral Director		5. Social Security Number  463-12-9976  Usual Residence of Decedent	7. Ag	95 Y	rs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 3-5-19	th ly, Ye <i>ar)</i> 08		Birthple Country Texa	ce (State or Foreig y) LS	gn
	he Maryland Ba-f show	ector	10a. State 10b. County MD Montgome	ry	10c. City, Town		ing							100	d. Inside City Limit	
	3a or 2	Dire	10e. Street and Number 200 Greenspring L	ane			10f. Zip (	<sup>Code</sup> 0904				10g. Cit USA	izen of Wha	t Countr	y?	
036	be filed within 72 hours after death with the Maryland ital Hygiene.  ad other than "natural", or fleme 23a or 28a-1 show event, I'ra Medical Eracia writtens its routiled at	by Funeral Director		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:				ent of His fy Cubar		jin? (Spec Puerto F	cify Yes or No lican, etc.)		14. Race - / Black, V Specify: 1	Vhite, et	c.	
9500-61212	I within 72 ho iene. r than "natur ina Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	5+)	(Give ki life. D(	nt's Usual ind of work O NOT use	Occupa done di retired)	tion uring most	of workin	i		onf.		,	
yland	2 should be filed value and Mental Hygie is marked other is aumatic event.	To Be C	17. Father's Name (First, Middle, Last) Rufus LaMascus						Maude	Dan	(First, Middle, e	Maiden	Sumame)			
M	alth and 27 is m r traum		19a. Informant's Name/Relationship (Type Pat Knauss - Daug		19b. 1	Mailing ) Gr	Address (	<i>Street ai</i> prin	nd Number g Ln.	or Rural Sil	Route Number	r, City o	r Town, Stai	e, <i>Zip C</i> 2090	ode) 4	
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury at other traumetic and once.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Ri  4 □ Donation 5 □ Other (Specify)		20b. Place of Commetery	ico1	n Cr	em.	1	Da	04	Bre	ntwoo	d, M		
D	Depa Impo any i		21. Signature of Funeral Service License	· Casa	uler	11	Name and $800~$ I	Address New	of Facility Hamps	Hin hire	es-Rin	aldi Silv	F. H	ring	, MD 209	n۷
***	icate be executed Whedical physicien and physicien and sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate days. Enter Uncertainty Cause (Disease or injury that inditated events resulting in death) Last	Essenti Due to (or as Atrial Due to (or as	al Hyper a consequence of Fibrilat a consequence of	ten : ion	sion							_3 <sup>to</sup>	pproximate ternal Between inset and Death	
.O. DOX 0	w requires that the death certific been signed by the atlanding p should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal death		ctopic preg other (spec					2	23d. Date of Month	delivery Da	y Year	13
ר (כטור	equires that en signed b	þ	Part II. Other significant conditions cont Degenerative Brain	ributing to death but Disorde	ut not resulting in t	he unde	arlying cau	ise given	in Part I.			bacco u:	_		cause of death?	1
יי וייי	elcian: The law ri certificate has be irector, page 2 shr	e Completed	25. Was case referred to medical								24a. Was a autops perform	med? 2X No	24b. Were prior death	to compl ?	findings available etion of cause of	,
IN SIGNI OF ALL	ng Pny fter this neral d	Certification: To B	examiner?	28a. Date of Injur (Month, Day	ry - At home, farm	ne of	280 M	Other: c. Injury a Work? 1  Ye	4 🗆 Nurs	ing Home	Check only on  5 Reside  Describe he  Location (St City or Town	ence 6 ow injury	occurred  Number or		ssisted iving	-
	lo the hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check offy one)  1	cian: To the best of	f my knowledge, o	death or	ccurred at	the time,	date and ion, death	place, and	el el co de disc			as state	d. ∋ cause(s)	
1	within To tr	Me	29b. Signature and title of certifier	rom	relle	1	/ 1	License r					signed (Mo			
			30. Name and address of person who com David Cromwell, M.	D. 831 U	Iniversit			E. :	Suite	#37	Silve	r Sp	ring,	MD :	20903	
	Star Registra		31. Date filed (Month, Day, Year)	32. Hegistra	r's Signature		Som	KN	,							

			1 - For State Registrar		aryland / De	partment	of Health and of Death	Mental Hygi	_	03966
	Physic /Medi		1. Decedent's Name (First, Middle, Las Milton Alexande	•				2. Date of Death Month January	n Day Yeer	3. Time of Death 2:50 a M
	Exami		4a. Facility Name (If not institution, give Suburban Hospit	street and number)			own, or Location of Dec		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Se 579-60-8137	X 7. Age ⊠M 2□ F	e (In yrs. last birthd 95 Yrs	Months	Year If Under 24 Hi Days Hours Mi		Year) 9. Bii	hthplece (State or Foreign ountry) shington, DC
	within 72 hours after death with the Maryland ene. then *natural', or items 23a or 28a-1 show the Macilial Examinar must be notified at	Director	10a. State 10b. County Maryland Montgome 10e. Street and Number	ery	10c. City, Town o	esda				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	23a or		6904 River Road			10f. Zip C	20817	10	g. Citizen of Whal Ci USA	ountry?
036	ours after des al', or items Examinar m	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		3. Was Decede If Yes, specifi 1 \( \text{Yes} \) 2	nt of Hispanic Origin? ( y Cuban, Mexican, Pue No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.
0-6121	within 72 ho sne. then *natur is Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4 or 5	+) (G		done during most of w retired)	orking	6b. Kind of Business	•
Maryland 21215-0036	ould be filed of Mental Hygie arked other fatic event, it	To Be Co	17. Father's Name (First, Middle, Last) William Schelle	5+ enberg		atholic	18. Mother's Na	ame (First, Middle, M. Mack	Religiou	15
ore, mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. San or 28a-1 show ment in the Markital Examinet must be notified at Once.		19a. Informant's Name/Relationship (7)  Thomas L. Samse1,  20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ F	/Nephew	20b. Place of Dis	416 Quai	Street and Number or F 11 Run Driv of er place) Janu	e, Darnes		20878
ballimore,	permit. Pa Departmen Important: eny injury once.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		Ge	metery	Address of Facility J. Colling versity Bl	2004 S	ilver Spr. Home Inc.	ing, MD
	nysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Respirat	the death. Do not e.  cory Fail: a consequence of):	enter the mode o	of dying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
g <sup>th</sup>	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Aspirati	on Pneumo	onia				
,007	ite be executed ysician and he burial-transit	Ical Examiner	Cause (Disease or Injury that infitated events resulting in death) Last		consequence of):	ion				
O. DOX 00	If the death certilicate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal death	3 □Ectopic preg 5 □ Other (speci			23d. Date of del	ivery Day Year
_	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying caus	se given in Part I.		cco use contribute to	the cause of death?
י שבי	ine iaw ate has b page 2 st	Completed						24a. Was an autopsy performe	id?   death?	topsy findings available completion of cause of
5 6	ig rnys Iter this neral dii	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 🖾 Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpat / 28b. Time / Year)		Other	ath (Check only one) Home 5  Residence 28d. Describe how		tify)
LINISION	to the trospinal or artening within 24 hours after death. To the Eurepeal Director After completely filled in by the funer.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc.				City or Town, S	,	
	the Fund the Fund the Fund	Medical	one)	sician: To the best of ner: On the basis of e and manner state	examination and/or	investigation, in	he time, date and place my opinion, death occi	a, and due to the causurred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
•	2 M 2 0		29b. Signature and title of certifier	btean			cense number		. Date signed (Month	
	>		30. Name and address of person who co Ramin Oskoui M.D 31. Date filed (Month, Day, Year)	. 3301 1	New Mexic	o Ave.,	NW, Wash			, 2004
	Sta Registr	-	JAN 23 200	32. Registrar	s signature	ppar	Kal			

0250 Am.

Ca Counter

Milton Schelleberg 1/18/04 @

			For Stete Registrer	State of N	Maryland / [	•	ment of H ficate of I		nd Mental I	Hygien Reg. N	6. U	04	03949
	Physicia /Medic		1. Decedent's Name (First, Middle SHERMAN		AUNDERS				2. Date of Month JAN		, 200	(ear ) 4	3. Time of Death 8:44 AM
•	Examin		4a. Facility Name (If not institution 2129 Hallma		r)	4	b. City, Town, or Gambr		Death		c. County of ANNE		NDET.
	Funeral Director		5. Social Security Number 210-40-2554		Age (In yrs. last bir		f Under 1 Year Ionths Days	If Under 24 Hours	Hrs. 8. Date o Min. (Month	Birth Day, Yea	r) !	9. Birthp	lace (State or Foreign try) Insylvania
			Usual Residence of Decedent						1102.	.,			
	larylan show	ក	MD Anne	Arundel	10c. City, Tow		rills					'	od. Inside City Limits  Y☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show r must be multihad at	Director	10e. Street and Number 2129 Hallma				10f. Zip Code	.054		1	Citizen of Wh		try?
	d within 72 hours after death w jiene. rthan "natural", or items 23a the Medical Examinar must.	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Deceder Armed Forces ied 1  Yes 2 If Yes, Give	s? <b>X</b> No	If Ye	s Decedent of H	spanic Origin	n? (Specify Yes o Puerto Rican, etc	r No-	14. Race -	Americ White,	
	72 hours "natural", dical Ex	Completed by	3 Widowed 4 Xi Divorced  15. Decedent (Specify only highes	Year or Dates t's Education at grade completed)		Deceden	t's Usual Occupa d of work done of NOT use retired	ation during most o	of working	16b.	Kind of Busi	ness/Inc	lustry
	within 72 iene. rthan "na rt Medic	ошр	Elementary/Secondary (0-12)	College (1-4o	r 5+)		ister	,			Reli	gio	n
3	be filed tal Hygi d other event. I	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (First, Mi				
		ဥ	Unknown 19a. Informant's Name/Relationsl	hin (Tyne Print)	19h	Mailing A	Address (Street a	and Number	Eva Sa			ate. Zio	Code)
	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic		Daun Lewis			•			or., Ga				
	Pages 1 aunent of Heannt: If item		20a. Method of Disposition 1 □ Burial 2 ⊠Cremation		ia I	ry, cremat	ory or other plac		Date / 0.4		Location - C exanc	•	
			* 4 □ Donation 5 □ Other (S)  21. Sign of Funeral Service	0 11	Metro	/22. N	eral S	s of Facility	L/26/04 SNOWDE	NFU	NERAL	HO	ME PA
3	permit. Depart Import any inj		Genge,	KANO	wall	FLF			St., R		ille,	MD	20850
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition		ed the death. Define.			g, such as ca	ardiac or respirato	ry arrest,			Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or a	as a consequence	of):	:=8		· RCC			1.	2 mo
	Examiner	ē	Sequentially list conditions, if any, leading to immediate		TOR P		RON	Di.	SEASE				YEARS
	icate be executed physician and s the burial-transit	l Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a consequence	of):							
	icate b	edical		d									
) ( )	The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death		topic pregnancy ther (specify)			_	23d. Date Monti		ry Day Year
	uires that the signed by Id be detac	d by Ph	Part II. Other significant condition	ons contributing to death	but not resulting in	in the unde	orlying cause give	en in Part I.			. /		e cause of death?
	The law require te has been si age 2 should t	Completed							8	Vas an utopsy enformed?	pri- de:	ere autopor to con ath?	osy findings available appletion of cause of
		BeC	25. Was case referred to medical examiner?						f Death (Check o				
		၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1  Inpa		utpatient Time of	3 DOA Other	4 🗆 14013	-	_	6 Other		)
	nding uth. r: After e fune	ation	Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, L		Injury	Work	k? Yes 2 □ No					
	To the Hospital or Attending Physician: • within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could determ	ined 286. Place of	Injury - At home, fa etc. (Specify)	arm, street	, factory, office		28f. Locati City of	on (Street a Town, Sta	and Number te)	or Rura	Route Number,
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier Certifyin (Check only one)	g Physicien: To the be Examiner: On the basis and manner	of examination an	e, death od nd/or inves	curred at the tin tigation, in my o	ne, date and pinion, death	place, and due to occurred at the ti	the cause( me, date a	s) and manr nd place, an	ner as sta d due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifie	1 1 -	AFF		29c. License	number	- 4	29d. D	ate signed	Month, I	Day, Year)
	6		Alut 1	102	Weloe			166	86		121/	20	04
	•		30. Name and address of person		f death (Item 23a)  N. Wol			Bal+	imore.	MD	2120	5	
	Sta	te	Ahmet Hoke, 31. Date filed (Month, Day, Year) JAN 22		strar's Signature	4	Sporks						
	Registr	ar	JAN ZZ	2004	1	1	yours						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n		1 - State Amend Item #1	State of Marylan per me G828	d / Dep 2/20/0	artmen Las rtificat	t of Hea e of De	alth and eath	d Men	tal Hygi	ene 2	004	0000
Physic		1. Decedent's Name (First, Middle, Last)  Kenneth Sydn						2. [	ate of Death Jonth	Day	Yeer	3. Time of Death 12:24 A M
/Medi Examii		4a. Fecility Name (If not institution, give s	treet and number)		4b. City,	Town, or Lo	cation of De		anuary	4c. Cou	2004 nty of Death	
		Southern Maryland				linton				Pri		orge's
Funeral Director		578-88-2275	7. Age (In yrs.		If Under Months		Under 24 H Hours M	lin.	pate of Birth Month, Day, C. 3,	<sup>Year)</sup> 1961		elace (State or Foreigr etry) ginia
d 2 should be filed within 72 hours after deeth with the Maryland to and Mental Hygiene.  27 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Evantinet must be notified at	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  District of Colu  10e. Street and Number  3600 Ely Pla  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  10th	mbia  ce, S.E. #11  2. Was Decedent Ever in U Armed Forces? 1  Yes, Give Year or Dates:	.S. 13.	Was Deceilf Yes, spet 1 ☐ Yes dent's Usukind of wo	dent of Hispa cify Cuban, N 2\( \overline{\text{N}} \) No S	Mexican, Pu Specify:  n n mg most of v	9 (Specify rento Rica	Yes or No- n, etc.)	14. F Spe	of What Coun United Race - Americ Black, White,	States an Indian, etc. ack
be filed ital Hygi of other svent, t	Be	17. Father's Name (First, Middle, Last)				18	. Mother's N	Name (Fir	Monda			
should be and Mental is marked o	မှ	Ronald S. Gra	<u> </u>			10			Marjo			0-4-)
12 sho h and 7 is m		19a. Informant's Name/Relationship (Type			•					•	wn, State, Zip	
a de E		Marjorie Sydnor  20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	20b. F	Place of Dispo cemetery, crei	sition (Name	me of other place)		Date 18/20	2	Oc. Location	$rac{ extsf{DC}}{ extsf{20}}$ on - City or To $ extsf{1}$ ford,	wn, State
permit. Pages of Department of Himportant: If its any injury or of once.		21. Signat le of Funeral Service License			2. Name ar	nd Address o					1 Home DC 2	0019
Physician / Medical Examiner physician and physician and the prigilitation and the prigi	dical Examiner	disease or condition resulting in death)  Squartially is condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	7284	10/12/20			17.5 V7.c			
death certifi e attending I ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl déath 3 🛚	Ectopic p						Date of delive Month	ory Day Year
requires that the	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying o	cause given ii	n Part I.				ontribute to th	ne cause of death? ably 4 Unknown
The law ate has b	Completed							-	24a. Was ar autopsy perform Yes 2	/	prior to cor death?	psy findings available npletion of cause of 2 No
Physician: Ti this certificate	Be	25. Was case referred to medical examiner?	ospital:			Other			e <i>ck</i> o <i>nly</i> one			
ding Phy h. After this funeral d	tion: To	27. Manner of Death  Natural 5 Pending	1 ☐ Inpatient 2 ☑ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injury at Work?		7	5   Resider		Other (Specify curred	/)
or Atten after deat Director: in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	reet, factor	y, office		28f. l	ocation (Str City or Town,	eet and Nu State)	mber or Rura	l Route Number,
o tospital	edical (	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	ician: To the best of my known of the basis of examina and manner stated.	owledge, death	h occurred vestigation	at the time,	date and pla on, death or	ace, and o	lue to the ca the time, da	use(s) and te and plac	manner as st	ated. the cause(s)
To the within 2 To the complete	Me	29b. Sip ature and title of certifier	- 1		29	c. License nu	umber		29	d. Date sig	ned (Month, I	Day, Year)
$\overline{\Omega}$		30. Name and address of person who co	mpleted cause of reath (Item	m 23a) (Type	Print)		O.C.	M.E.	J	anuar	y 10,	2004
7	-	MARGALIA A.	KORTLE	11		nn Str	eet,	Balt:	imore,	Mary	land 2	1201
St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 2 2004	32. Registrar's Signa	ature Land	8,							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year \_Month **Physician** 12:26PM 13 2004 JANUAKY SYLVIA PLATER SMITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 280 F Yrs 577-46-1488 MARYLAND Director 1933 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show 10a State 10b County 1 Yes 2 No PRINCE GEORGE'S LANHAM Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Fagrener must be r 20706 U.S.A. 9803 STALL AVENUE death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Itel 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: BLACK Specify. 3 ☐ Widowed 4 ☐ Divorced or than "nature the Medical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) POSTAL CLERK GOVERNMENT 17 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be **EDNA** EARL LEON PLATER SR. Tabbs ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9803 STALL AVENUE LANHAM, MARYLAND 20706 JAMES EARL SMITH Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
eny injury or ot
once. 1 N Burial 2 □ Cremation 3 □ Removal from State Maryland National 1-20-2004 LAUREL, MARYLAND \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 13 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CARDIOGENIC SHOCK resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of The law requires that the death certificate be executed burial-transit DIABETES Exam resulting in death) Last Due to (or as a consequence of) Box 68760. physicien Physician/Medical the as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No Division of Vital Records. P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by RESPIRATORY FAILURE 1 Yes 2 No 3 Probably 4 Minknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RENAL FAILURE page 2 1□ Yes 2 No certificate To the Hospitel or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No patient 2 ER/Outpatient 3 DOA ို (Month, Day Year) 27. Manner of Ceath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturai 5 Pending investigation s after dec. м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours at the Funerel Distributed in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2

To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 034525 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4000 MITCHELLUILLEROAD SOTTE 220 BOWIE MD 20718 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 🧻 🚉 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:02 P M Debra Ann Saulino 2004 Jan. 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel 8. Date of Birth (Month, Day, Year) ADr. 28,1953 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🗓 F 577-74-8421 50 Yrs. Wash., D.C. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f show the Medical Exeminer must be notified at 1 Yes 2 No Director Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 12711 Buckingham Drive USA Items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Marketing 12 permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg Importent: If Item 27 is marked other eny injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George E. Frazee, Sr. Patricia Ann Elliott 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward L. Frazee / brother 12711 Buckingham Dr. Bowie, MD. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 1-24-2004 Davidsonville, MD. \* 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Highway Bowie, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf disease or condition Physician Defect in aortic aneurysm rejair with hemorrhage resulting in death) /Medical Due to (or as a consequence of): **Examiner** and massive left pleural effusion S pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Aortic aneurysm repair 4 Unknown 1 Yes 2 No 3 Probably Infarction of bowel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes Yes 2□No 1 🗌 Yes Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 XER/Outpatient 3 DOA Certification: To ihis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after decreal Director: Altractor Altractor М 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide on 24 hours. the Funeral Direction Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W D 24721 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Rd. Syed Sadiq, M.D. Laurel, MD. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 2 0 2004 Registrar

			1 - For State Registrar	State of	Maryland / D	epartment o Certificate o				iene g. No.	Constant of the Constant of th	03953
	Dhysiai		1. Decedent's Name (First, Middle, Las						<ol><li>Date of Deat Month</li></ol>	h Day	Year	3. Time of Death
	Physici /Medic		EDNA LEE SHO	JLDERS					January	11	2004	8:15 A M
1	Examin	er	4a. Facility Name (If not institution, give				m, or Location o	of Death			nty of Death	
			Washington Adve				na Park	24 Ure	O Data of Blat		gomery	
	Funeral		5. Social Security Number 6. Social Security Number 1	x □M 21€F	. Age (In yrs. last birth		ays Hours	Min.	8. Date of Birth (Month, Day, April 1.	Year)	9. Birthp Cour	
	Director		Usual Residence of Decedent		72 Y			Į E	аргтт т.	5, 195	n Mar	yland
	tand		10a. State 10b. County		10c. City, Town	or Location	<u>.                                    </u>				1	0d. Inside City Limits
	Mary	ğ	Maryland Prince (	enroe's	B1aden	shuro						18 Yes 2 No
	28s	Director	10e. Street and Number	COLGC B	Diagon	10f. Zip Cod	de		1	0g. Citizen	of What Cour	ntry?
	3a o		5999 Emerson Str	eet		207	10			U.S.	Α.	
	72 hours after deeth with the Maryland natural; or items 23s or 28s-f ehow dreal Examinar must be motified at	Funeral	11. Marital Status	12. Was Deced Armed Force	ent Ever in U.S.	13. Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Spec	city Yes or No-		lace - Americ	
9	or the		1 ☐ Never Married 2 ☐ Married	1 Tes 2	IK No	1 ☐ Yes 2 ፟፟፟፟፟፟፟፟፟፟፟			ilican, dic.,	1	$_{cify}$ : B $f 1}a$	
8	irait',	d by	3 Widowed 4 Divorced	Year or Dat	es:							
5-	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. C	Decedent's Usual Oc Give kind of work do life. DO NOT use re	ccupation one during most	t of working	g	16b. Kind of	Business/In	dustry
121	within ene. than "	dm	Elementary/Secondary (0-12)	College (1-4	for 5+)	Singer	eurea)			Ente	rtainm	nent
2	7 7 2 4		17. Father's Name (First, Middle, Last)		1		18. Mothe	er's Name	(First, Middle, M	Aaiden Sum	ame)	
and	e d ita	Be	Edward Palmer									
2	should be nd Menta marked umatic ev	은	19a. Informant's Name/Relationship (	vpe. Print)	19b. I	Mailing Address (Str			Harper		vn. State, Zip	Code)
Maryland 21215-0036	2 6 8 6		Johnny Shoulders		59	99 Emerso	on Stree	et. B	1adensb	urg.	Marvla	nd 20710
ē,	s 1 and 3 I Health Item 27 other tra	116	20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other	of	Da			n - City or To	
Ę	Peges nent of I nnt: If it	- 1	1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specify		ate	incoln Ce		01/15	/2004 F	Brentw	ood. M	farvland
Baltimore,	그 문원 등		21. Signature of Funeral Service Licen	see		22. Name and Ad	ddress of Facility	ly		, , , , , , , , , , , , , , , , , , , ,		id Ly Lund
Ö	Deparenti Impo		Mydin T. Klever	A Mor	522	FORT LING	COLN FUI densbur	NEKAL g Roa	. HOME .d. Bren	twood	, Mary	land 20722
	T = 1		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	dications that cau	used the death. Do no	t enter the mode of	dying, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		11 the rot	> Can	d 366 V	11/6	Alle	2010		Onset and Death
	/Medical		resulting in death)	Due to (or	r as a consequence of	):	<u> </u>					
	Examiner		Saquentially list conditions, if any, leading to immediate	b		100						
	bed sit	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	ras á consequence of	):						
_	xecut and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or	r as a consequence of	):					-	
8760,	sicien and burial-transit			,		•					ĺ	
687	ate hy:	Physiclan/Medical		d								
Box (	eath certific attending p for use as 1	N/M	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy					23d.	Date of delive	ery
ă	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 <b>1</b> No	4☐Pregnar	th 2 ☐ Fetal death nt at time of death	3 ☐Ectopic pregn: 5 ☐ Other (specif)			M M		Month	Day Year
0	res that the de signed by the a be detached t	hys	9 Unknown	9□ Unknov	vn 							
Э, Р	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions c	-	•	he underlying cause	e given in Part I.		23e. Did tob	acco use co	ontribute to th	ne cause of death?
ğ	v require been sig should t	ed	Congestive Hea	NT 72	ive				1 🗆 Ye	s 2 No	3 Prob	ably 4 Munknown
သွ	as be	plet	Hepatic Such	phalop	and Day				24a. Was an		b. Were auto	psy findings available inpletion of cause of
Vital Records,	o	Completed			,				perform	ed? No	death?	
ita	ian: Th srtificate ctor, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death	(Check only on	θ)		
of V	Physician: r this certific ral director,	ပ္	1 ☐ Yes 2 😿 No		patient 2 ER/Outp			ırsing Hom	e 5 🗆 Reside	nce 6 🗆	Other (Specifi	y)
n o	ding Ph h. After th funeral		27. Manner of Death  1. Natural 5 □ Pending	28a. Date of (Month)	Injury 28b. Ti , <i>Day Year)</i> Inj		Injury at Work?		Bd. Describe ho	w injury occ	urred	
sio	Attending ir death. actor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	-			1 Yes 2 1					
Division	or Attend after death Director: /	Certification:	4 Homicide determined	286. Place 0	if Injury - At home, farr g, etc. <i>(Specify)</i>	n, street, factory, off	fice	28	City or Town		mber or Hura	I Route Number,
	pitel ours a eral (		29a. Certifier 17 Certifying Ph	veicisa: To the h	pest of my knowledge,	death assured at th	no limo, data an	d place of	ad due to the or	uso(a) and		ated
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exam	niner: On the bas	sis of examination and	or investigation, in	my opinion, deal	th occurred	d at the time, da	ate and plac	e, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Six and title of certifier	0.	0		cense number		2:	9d. Date sig	ned (Month,	Day, Year)
			Anlles	aw.	re hu	(4)	018	52	2 ~	142UA	ing 17	2 2004
)	(3)		30 Name and address of person who	completed cause	of death (Item 23a) (T	ype, Print)	,	4		2.55 2.55		11 1 A 1 -
			Paul A. Del	bet N	4203	Wells	MUGST	1 Ret	44	9775	U1 1/e	2004 MY 2024
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month Yaar **Physician** THELMA STACKHOUSE 5:10 AM January 9,2004 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Prince George's Examiner Cheverly Prince George's Hospital & Nursing Home ff Under 1 Yaar Months Days If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 6 Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number **Funeral** Hours Months 1□ M 2∏ F 579-20-1688 Yrs. 78 May 13,1925 unknown Director Usual Rasidenca of Dacedant 10d. Insida City Limits with the Marylend 10c. City, Town or Location 10a. State 10b. County if Heelth and Mantel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at 1 XYas 2 □ No Cheverly Prince George's Directo 10g. Citizan of What Country? 10f. Zip Coda 10e. Street and Number USA 20785 2900 Mercy Lane Funerai 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. unknown 1□ Navar Married 2□ Married Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mentel Hygiene.
ant: If item 27 is marked other than "natursi", or ite 1□ Yas 2□ No If Yes, Giva Yaar or Datas: Unknown 1 ☐ Yas 2 ☐ No Specify: altimore, Maryland 21215-0020 Specify: Black δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complatad) Elamantary/Secondary (0-12) Collaga (1-4or 5+) unknown unknown unknown 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nema (First, Middla, Last) unknown unknown 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5012 Rhode Island Avenue, Hyattsville, MD 20781 19a. Informant's Nama/Ralationship (Type, Print) Joann Butler/Guardian Specialist 20b. Place of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Depertment of Pimportant: If its any Injury or of pace. 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State 1/14/04 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Nama and Addrass of Facility Cedar Hill Funeral Home, Inc. nature of Funeral Service License 4111 Fennsylvania Ave., Suitland, MD 20746 Approximata Interval Batween Onset and Death 23a Part. Entar the disease, or complications that causad the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician /Medical Immediata Cause (Final List 000 disaasa or condition rasulting in death) Examiner Dua to (or as e consequança of): Physician/Medical Examiner ettending physician end for use es the burial-transit or Attending Physician. The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or es a conseguance of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the e 1 ☐ Yes 2 ☐ No 3 Probabty 4 Unknown 90 ģ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? outses 1 Yes 24Ko 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Othar: 4 Nursing Homa 5 Residance 6 Othar (Spacify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 1 Yes 2 No this After this 27. Manner of Death 1 ☐ Natural 28e. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yas 2 ☐ No s efter deeth. I Director: A od in by the fu investigation 2 Accidant 6 Could not be 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicida Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 - Homicida within 24 hours eff To the Funeral Di completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date end place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of axemination and/or invastigation, in my opinion, death occurred at tha time, date and placa, and dua to the causa(s) and mannar stated. edicai 29b. Signatura and titla of certifian 29c. Licansa number 29d. Date signad (Month, Day, Year) p + 920-079 2 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) on That Exercise 11. 2002 Lanh Den W. Yablanovila

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 2 2004

32. Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARIE **JANUARY** 18:39 PM ADELE TYDINGS 20 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 28 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2⊅F Yrs. 056 16 3356 84 New York Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State \*ehow rai', or itame 23a or 28a-f ehor Examiner must be notified at 1 Yes No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15423 Bassett Lane United States Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes 2XNo Baltimore, Maryland 21215-0036 Specify White Specify. þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ith and Mental h 27 is marked of traumatic evan Leon Joseph Roversi Mary Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Richard T. Lichtermann / Husband 15423 Bassett Lane, Silver Spring, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crem. 1/21/04 Alexandria, Va. \* 4 ☐ Donation 5 ☐ Other (Specify) Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses P. O. Box 5038, Laytonsville, Md. 20882 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACRANIAL BLEED 3 Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2No 3 Probably 4 Unknown HYPERTENSION CHRONIC RENAL FAILURE 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No ARTHRITIS 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No Certification: To ieral Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of 1 2 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18726 JANUARY 21, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 18111 PRINCE PHILIP DRIVE, OLNEY, MD. ARTHUR SCHOENGOLD, 31. Date filed (Month, Day, Year) JAN 22 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryl		artmen rtificat			ind M	Re	g. No.	0	03956
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of Death Month	Day	Yeer	3. Time of Death
	/Medi		Chan Van		.,	4h Cih.	Town or	Location of	f Dogth	January	4c. County	2004	10:00 PM
7	Examir	er	Doctor's Communi				anha		Death				eorge's
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday, 50 Yrs.	) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, July 3,		9. Birtho	place (State or Foreign ntry) t Nam
	put *		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or L	ocation						1	0d. Inside City Limits
	Maryli f sho	ō		George's	Lanha								1 ☐ Yes 2 🎇 No
	28a-	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of	What Cour	ntry?
	th with	ai D	7631 Seans Terra	ce			207	706			U.S	. A .	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "naturel", or items 23a or 28a-1 show may july or other traumatic svent, the Modical Examiner rount be notified at ODGS.	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedif Yes, spec		ispanic Orig in, Mexican, Specify:	gin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)		ck, White,	an Indian, etc. sian
S O	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	edent's Usua kind of wor DO NOT us	al Occupa	ation during most	of workii	na 1	6b. Kind of B	usiness/in	dustry
2	nen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)							Λ <del>1</del> 20 2	1000	Dowto
2	Hygien Hygien ther ti nt, in		9 17. Father's Name (First, Middle, Last,		Mac	hine	oper		r's Name	(First, Middle, M			Parts
and	d be f	To Be	Ky Van Truong							Huynh			
37	should be and Ment marked umatic	۴	19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address	(Street	and Number	r or Rura	l Route Number,	City or Town,	State, Zip	Code)
	and 2 alth a 127 is		Trai Nguyen /	wife	763	31 Sea	ns I	errac	e, L	anham, N	Marylar	nd 2	0706
ore	of He		20a. Method of Disposition 1 Burial 2X Cremation 3	Removal from State	b. Place of Disponentery, cre	matory or o	ther plac				Oc. Location -		
Ĕ	Pag ment tant: I	13	* 4 □ Donation 5 □ Other (Specif	y) F(	ort Line								Maryland
Baltimore,	permit Depart Import eny in		21. Sign up of Tuneral Strivice Liber	De for									Home, Inc. g, MD 20904
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause of each line.	death. Do not en	ter the mod	le of dyin	g, such as o	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
B	/Medical Examiner		Todaling in dozesty	Due to (or as a con		o a f a							
4		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	n Metast sequence of):	asis		_					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events	c								- 1	
760,	icate be executed physician and s the burial-transit	cai Exa	resulting in death) Last	Due to (or as a con	sequence of):								
687				d						-			
.O. Box	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pr ⊒ Other (sp						te of delive	ery Day Year
₾.	ires that I signed by d be detai	þ	Part II. Dther significant conditions of	contributing to death but not	resulting in the u	underlying c	ause give	en in Part I.					ne cause of death?
Sor	w requ	iete								24a. Was an	24b.	Were auto	psy findings available
Division of Vital Records,		Completed									ed? [ŽNo	prior to cor death? 1  Yes	inpletion of cause of
₹	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient	2 🗆 ER/Outpatie	ot 20 00	Othe	25		(Check only one ne 5 ☐ Resider		or (Specifi	.)
o	g Phya er this	-	27. Manner of Death	28a. Date of Injury (Month, Day Yea.	28b. Time o		28c. injun Work			28d. Describe hov			7)
<u>o</u>	Attending Fir death.  ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	r) Injury	М		Yes 2 N	10				
Divis	P C C	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory	, office		2	28f. Location (Stre City or Town,		er or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funerel Dirticompletely filled in I	Medical	29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Example 1	nysician: To the best of my niner: On the basis of examand manner stated.	knowledge, deat nination and/or in	th occurred nvestigation	at the tim , in my of	ne, date and pinion, death	d place, a h occurre	and due to the cau	use(s) and ma te and place,	and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			290		number		29	d. Date signe	d (Month,	Day, Year)
			X 3 . 3	7				D5818	2		Januar	y 12,	, 2004
	10		30. Name and address of person who	completed cause of death (	item 23a) (Type, )5 - A H	Print) (	r Pa	l D (	Geoe , Gr	eenbelt,	Mary1	and 2	20770
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature &	Spo	nks	/					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1-15-04 **Physician** 10:45 AM Marina Tovar /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Dey, 8-8-48 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F 55 Vrs Columbia Director 577-72-1547 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County urel', or items 23e or 28e-f ehow | Examinar roust be notified at 1 ☐ Yes 2 ☑ No Directo MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2102 Harlequin Terr 20904 Columbia death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I important: If item 27 is marked other then "naturel", or itel important: If item 27 is marked other then "naturel", or itel eny injury or other traumatic event, the Medical Examatina once. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Columbian Baltimore, Maryland 21215-0036 1⊠ Yes 2□ No Specify: Hispanic þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maria O. Bonilla Marco Antonio Tovar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2102 Harlequin Terr. Silver Spring, MD 20904 Victoria Marin -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 1-20-04 Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi F. H. 21. Signature of Funeral Service Licensee Musue 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic uterine cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the turneral director, page 2 should be detached for use as the buriat-transit completely filled in by the turneral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 2X No 1 Yes I ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 1-15-04 aga 30. Name and address of person who completed cause of denth (tem 23a) (Type, Print) 1517 Hugo Cir. Silver Spring, MD 20906 Alan R. Segal M. S. 32 Registrar's Signature 31. Date liled (Month, Day, Year)

JAN 2 0 2004 State Registrar

		•	For State Registrar		aryland / Depa		lealth and N	Mental Hy	niono.	03958	)
	Physici	an	Decedent's Name (First, Middle, Lass Shirley	Jean	) n	Chompson		2. Date of Dea	y 12, 20	3. Time of Death	
	/Medic Examin	al	4a. Fecility Name (If not institution, give Laurel Regional H	street and number)		4b. City, Town, o	r Location of Death urel		4c. County o	7,700	
	Funeral Director		213-44-0073	ox 7. Ag	e (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV. 1,	h Y Year) 1928	<sup>9.</sup> Birthplace (State or Foreign Country) Pennsylvania	7
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's	10c. City, Town or Lo Beltsvill					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	h with the 13a or 28a st be not	Funeral Director	10e. Street and Number 4508 Tonquil Plac	е		10f. Zip Code 207	05		10g. Citizen of W United	hat Country? States	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	٥	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1☐ Yes 2☐ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. White	
21215-0036	vithin 72 ho ine. .hen "natur e Mudical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5	(Give life.	dent's Usual Occup b kind of work done DO NOT use retired istrative	during most of won d)	1	16b. Kind of Bus	siness/Industry  Government	
	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the Ma	To Be Co	17. Father's Name (First, Middle, Last) James Cousins He	pler	Actions	isciacive	18. Mother's Nam		Maiden Sumame		
Maryland	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (7 Edwin R. Thompson			ng Address (Street  3 Tonquil				State, Zip Code) and 20705	
Baltimore,	ent of Hea		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify		20b. Place of Dispo cemetery, cre Metropoli	matory or other place	atory 1/1	Date 7/2004		City or Town, State ria, Virginia	
Balti	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other trau		21. Signature of Funeral Service Licen		4	30naid V. 400 Powde	Borgward	lt Funera	al Home, ville, M	P.A. aryland 20705	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one čause on each li	the death. Do not en ne.	ter the mode of dyir				Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	Head for tens	im					
,092	certificate be executed ading physicien and use as the burial-transit	icai Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
.O. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live binth 4□Pregnant al 9□Unknown	2 Fetal death 3	□Ectopic pregnance □ Other (specify) _	у		23d. Date Mon	e of delivery th Day Year	
ds, P.	w requires that the death been signed by the atte should be detached for	d by Pł	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	underlying cause giv	ven in Part I.			ibute to the cause of death?  3 Probably 4 Unknown	ı
Division of Vital Records,	The lar te has age 2	Completed by						1 ☐ Yes	osy pr rmed? de 2 2 No 1	Vere autopsy findings available rior to completion of cause of eath?	8
Vita	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Ott	26. Place of Dea		<i>ine)</i> dence 6 □Othe	or (Sagaibi)	
on of	ng fe ine	tion: To	27. Manoer of Death  1 V Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ırv 28b. Time o	of 28c. Injur	ry at		now injury occurre		
Divisi	or Atter ter dea irector n by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tox		er or Rural Route Number,	
	Hospitel of the said of the said the sa	edical								nner as stated. and due to the cause(s)	
	To the 2 within 2 To the 3 complet	Med	29b. Signature and title of certifier		ateu.	29c. Licens	_		_	(Month, Day, Year)	
	9		30. Name and address of person who				53709	0		14/04	
			KAT CHHWL	A 300	oo mit	chell vil	le vd	Bow	ie M	ID 20716	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 21 2		rar's Signature	Spark	N				

State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	Death		Reg. No.	UN	00202
			1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	ath	V	3. Time of Death
	Physici		James C. T	Curner, Sr.				January	Day 7 15 2	2004	11:30 AM
٠,	/Medic Examir		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or I	ocation of Deat		of Death	
	LAGIIII	101	St. Thomas Mc	re Nursing Hom	ne		Hyatts	sville	Pr	ince	George's
-	Funeval		A CAN A MARKET		s. last birthday)	If Under 1 Year		8. Date of Bir	th .	9. Birthpla	ace (State or Foreign
	Funeral Director		579-50-6969	4014 000	3 Yrs.	Months Days	Hours Min.	June J	th L, Year) 1940	Covint Wa	sh., DC
			Usual Residence of Decedent								
	dand		10a. State 10b. County	10c. 0	City, Town or Lo	cation				10	d. Inside City Limits
	Mary	5	Maryland Princ	e George's		Hyattsvi	116				1 TYes 2 □ No
	28a	Director	10e. Street and Number	e dedige b		10f. Zip Code			10g. Citizen of	What Count	rv?
	with with		4922 LaSalle	Pood			20782		-		States
	eath	Funeral		12. Was Decedent Ever in	11 S 12 V	Vac Decedent of H		necify Ves or No		e - America	
	ler d	Ë	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?	0,0. If	Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puert	Rican, etc.)	Bla	ck, White, e	
8	s aff	J.	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2XINo	Specify:		Specif	<sub>v:</sub> B1	ack
8	hour al	<u>8</u>			16a Doord	ontin Usual Occum	nation		16b. Kind of B	usinoss/Indi	uetne
<u>.</u>	and and and and and and and and and and	Completed	15. Decedent's (Specify only highest)	grade completed)	(Give I	kind of work done	nation during most of world)	king	TOD. KING OF B	usii 1622/11 (0)	цэну
12	A Par	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)	me. D				מד	rivat	0
2	led v lygie her 1		12th 17. Father's Name <i>(First, Middle, L</i> a	o el		Truck	Driver 18. Mother's Nam	o (Eiret Middle			e
Maryland 21215-0020	tal F d otl	Be		•			18. Mother's Nam	, .		•	
₹	ould Men mrke ertic	မ	James H						Hairsto		
<u>ā</u>	d 2 should be filed within 72 hours after death with the Maryland hand Mental Hyglene. 7 Is merked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exertines must be rigitled at	6 10	19a. Informant's Name/Relationship	, , , ,			and Number or Ru				
2	4430		James C. Turner	, Jr Son	510	4 Kenilw	orth Ave	., ∦6, h	iyattsvi	.ire,	MD 20781
ē	es 1 and of Healt fitem 2		20a. Method of Disposition		Place of Dispos cemetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location -	City or Tow	vn, State
Baltimore,	Pages nent of int: If ite iry or o		1√ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	-	oln Ceme	-	1/22/04	Brent	wood.	MD
≡	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.		21. Signature of Funeral Service Lic			Name and Addre	ss of Facility				
ñ	Ped in ped and	V 6	I L T	- St.	1				Tuneral	_	0010
			John I	· afteroux,	الملل		nning Rd				0019
		3 13	23a. Part1. Enter the disease, or co shock or heart failure. List on	implications that caused the dealy one cause on each line.	ath. Do not ente	er the mode of ayin	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		The Court (First							1	ongot and boats
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Duodena	1 Cance	r				1	
			resulting in death)	Due to	(or as a consequ	uence of):					
	D #	n/Medical Examiner		■ b				_		1	
	certificate be executed nding physiclan and use as the burial-transit	Кап	Sequentially list conditions,	Due to	(or as a consequ	ionee ol):				Ţ	
Ž,	lan a	<u>E</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							- 1	
98/90	ate t hysic the b	200	that initiated events resulting in death) Last	Due to (	or as a consequ	ence of):				i	
Õ	ng p	Š		<b>.</b> .							
ŏ				d						1	
מ	the death y the atte ached for	Physicia	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause give	en in Part I.	23b. Did 1	obacco use co	ntribute to t	the cause of death?
S.	t the	چَ	Camanama	Artery Diseas				1 🗆	Yea 2√⊡ No	3 Proba	ibiy 4 □ Unknown
, v	s tha	ξ	Coronary	Altery Diseas							
Records,	law requires that the deatt as been signed by the atte 2 should be detached for	교	Hyperter	ocion				24a. Was	an autopsy		e autopsy findings lable prior to
္ပ	v rec	<u>a</u>	nyperter	ISTOII				репо	rmed?	com	pletion of cause eath?
e E	e lav	Completed						450	res 2⊠ No		
=	n: The icate h		05.14	1				1 1		1 🗆	Yes 2□ No
VII	Physician: The law this certificate has b iral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		all DOA Othe	26. Place of Deat		_		
5	F ig i	ဥ	1 ☐ Yes 2 ② No	1 Inpatient 2L	28b. Time of	3LI DOA	4 Lawursing no		dence 6 Oth		
Ē	ding F h. After funer	5	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl		200. Describe r	low injury occurr	90	
Vision	eath or: /	cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	h-			Yes 2□No			5	
₹	al or Attending F s after death. I Director: After id in by the funer	Certification:	4 ☐ Homicide determine		nome, tarm, stre ify)	et, factory, office		City or Tou	Street and Numb m, State)	er or Hurai i	Houte Number,
2	ral D						<u> </u>				
	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex	Phyaician: To the best of my kn aminer: On the basis of examin							
	the hin 2 the l	g e	one)	and manner stated.							
	<b>6</b> ₹ <b>6</b> 0	Σ	29b. Signature and title of certifier	0 4		29c. License		1	29d. Date signed		
	~ ~		15,010	mul 1	4	D	0058390		Januar	у 16,	2004
1	1)/31		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type, P	rint)	TT 1 D:	7 00000			
1	14		S. Hamwi, M.D.	1328 Southe	ern Ave.	<i>,</i> #307,	wash., Do	20032	<u>-</u>		
	Sta		31. Date filed (Month, Day, Year)	3. Registrar's Sign	nature	-0					
4	Registra	ar	JAN 2 2 201	14 Beine A	Appea						
					- /						

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryla			of Health a of Death	ind Menta	al Hygier Reg. I	71111	03960
	Physici	an	1. Decedent's Name (First, Middle, Last Janie C. Toy	)				44-	te of Death onth nuary I	2004°	3. Time of Death
*	/Medic	al	4a. Fecility Name (If not institution, give	street and number)		4b. City. T	own, or Location o			4c. County of Death	4:59pm
	Examir Funeral Director	ier	Southern Maryland 5. Social Security Number 6. Se	Hospital	rs. last birthday) Yrs.	Clir If Under 1	nton	24 Hrs.   8. Da		Prince Ge	
4	p ,		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	cation					10d. Inside City Limits
	laryla ehov	ō	DC DC. County		Vashingto						1, No 2 □ No
	28a-I	rect	10e. Street and Number		tasiiing C	10f. Zip (	Code		10g.	Citizen of What Cou	untry?
	h with	D	703 10th St NE			200	002		Un	ited Stat	es
920	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or iteme 23e or 28e-f ehow empty iquty or other traumatic event, the Medical Examinan must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Decede Yes, speci	ent of Hispanic Original Cuban, Mexican Specify:	gin? (Specify Ye , Puerto Rican,	es or No- etc.)	14. Race - Amer Black, White Specify: Bla	, etc.
21215-0036	within 72 hou ana. then "natura he Medical E	Completed	15. Decedent's Ed. (Specify only highest grad		(Give I	kind of work OO NOT use	Occupation k done during most e retired)	of working		. Kind of Business/li	ndustry
d 2	Hygie Hygie other		17. Father's Name (First, Middle, Last)		Homen	IGICOL	18. Mothe	r's Name (First,			
<u>a</u>	Mental Mental rked ticev	To Be	John McKinley P	osey			Mari	e Montg	omery		
Maryland	and N		19a. Informant's Name/Relationship (T)			_				y or Town, State, Zi	ip Code)
∑.	and 2 ealth m 27		William Toy Jr./				St NE Was	hington Date	4-19	002 Location - City or T	Contract Con
Baltimore,	Peges 1 ment of H ent: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F Donation 5 ☐ Other (Specify)	Removal from State		oln C	Cemetery	1/15/20	04 B1	adensburg	
Balt	permit. Depart Import eny Inj 2002		21. Sign and of Funeral ServicerLicens	Mass	> A1 26	Name and exand	ler S. Po	pe Fune E Washi	ral Ho	me DC 20020	
	Pnysician /Medical Examiner		23d Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the done cause on each line.  a	n'4	er the mode	of dying, such as o	cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Wijer) that infittated events resulting in death) Last	Due to (or as a cons							
P.O. Box 687	Attending Physician: The law requires that the death certificate r death.  sctor: Atter this certificate has been signed by the attending physical that tuneral director, page 2 should be detached for use as the	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time of 9□Unknown	etal death 3	Ectopic pre				23d. Date of delin	very Day Year
	quires that n signed b ald be deta		Part II. Other significant conditions co acute Kenal Fai have	ntributing to death but not	resulting in the un	nderlying ca	use given in Part I.	23		o use contribute to 2 ☑ No 3 ☐ Pro	the cause of death?
Vital Records,	nysician: The law requir nis certificate has been si I director, page 2 should	Completed	7						a. Was an autopsy performed Yes 2	prior to co	opsy findings available ompletion of cause of
Vita	ician certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Other	of Death (Chec			-
	ding Phys h. After this funeral dir	tion; To	27. Manner of Death  1 Natural 5 Pending	1 ☑Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of Injury	-	A 4 Nur  Sc. Injury at Work?  1 Yes 2 1	28d. De		6 Other (Speci njury occurred	ify)
Division of	after death. Director: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, streecify)	et, factory,	office		cation (Street y or Town, St	and Number or Rui ate)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred a restigation,	it the time, date and in my opinion, deat	d place, and due th occurred at th	e to the cause ne time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of perifier			29c.	License number		29d. l	Date signed (Month,	, Day, Year)
k			Kamer	WD		20	055120		JAM	11 2004	
R	(4)		30. Name and address of person who call chard Palmen MD	ompleted cause of death (i	n An SE	Print) frute 3	10 Wahng	tin De	20032		
8	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 1 2004	i 3 2 % Samur Registrar's Si	gnature	de)	,				

		1 - State 1-20-04 Registrar Amend #29c		-		rtificate		h		Reg. No.	2001	0396
Physici	an	Decedent's Name (First, Middle,	Last)					1	2. Date of De. Month	ath Day		3. Time of Death
/Media	al	Wendell Jose 4a. Facility Name (If not institution, g		-1		4b. City, Tov	um or Locatio	or of Death	Janua		4, 2004 County of Dea	
Examir	er				or		everly				ince Ge	_
Funeral		Prince George's 5. Social Security Number 6			er last birthday)	If Under 1 Y	ear If Unc		8. Date of Birt		9. Bir	thplace (State or Foreig
Funeral Director		578-12-1409	1 <b>⊠</b> M 2□F	86	Yrs.	Months D	ays Hour	s Min.	B. Date of Birt (Month, Da 9/10/1	7 (19a <i>r</i> )		h.,D.C.
		Usual Residence of Decedent		100 0	ity, Town or Lo						was	10d. Inside City Limit
incommittee in the state of the	5	10a. State 10b. County D.C.		i	Washing							Yes 2□N
28a-1	Director	10e. Street and Number			100112119	10f. Zip Co	de			10a. Citi:	zen of What Co	
Na or	ā	2015 Lawrence S	t NE			70.1.2.1	200	18		111	U.S.A.	,
ms 2	Funeral	11. Marital Status	12. Was Deceder	t Ever in t	J.S. 13.	Was Decedent If Yes, specify	of Hispanic	Origin? (Spec	fy Yes or No	_	14. Race - Ame	
ial hygiene. Id other than "natural", or items 23a or 28a-f show event, itte Medical Exercitmic must be multified at	by	1 ☐ Never Married 25② Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Pyes 2  If Yes, Give  Year or Dates		45	1 ⊡ Yes 2XX			ican, etc.)		Black, White Specify:	Black
natur Iscal	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual O	ccupation	nost of working	9		nd of Business	•
I WAS	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use re	etired)				sus Bur	
ther th	Co		2 yrs.	·	Stati	stical_			(Simo Adiatale		. Gov't	•
	Be	17. Father's Name (First, Middle, La	(ST)						(First, Middle,		Sumamej	
marked imatic e	2	John E. Tracy  19a. Informant's Name/Relationship	(Type Print)		19h Maili	ng Address (St			tha Bro Boute Number		Town State	Zin Code)
17 is m traum		Evelyn J. Tracy/				Lawren						
item 27 is marke other traumatic		20a. Method of Disposition		20b.		osition (Name o		Da			cation - City or	Town, State
= =		¹XDBurial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe		Θ		n Nat'		- 1/27	/04	F+	Myer,	Va
Important: If it any injury or o once.		21. Signature of Funeral Service Lic	censee	-	23	Name and A H.S.Wa 925 Bur	ddress of Far Shingt	on & S	ons Co	.,In	C.	20019
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	ed the dea	th. Do not en	ter the mode of	dying, such	as cardiac or	respiratory ar	rest,	,D.C. 2	Approximate Interval Between
dical nine prize transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d. d.	is a consec	quence of):							
ng ph a as th	Med	IF FEMALE:								1		
tached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fet	al death 3	Ectopic pregn Other (specif				2	3d. Date of de Month	ivery Day Year
ep ec	þ	Part II. Other significant conditions	s contributing to death	but not res	sulting in the u	nderlying caus	e given in Pa	rt I.		bacco us		o the cause of death?
has been si je 2 should i	Completed								24a. Was autop	sy	24b. Were au prior to death?	itopsy findings availab completion of cause of
			_							2 12 No	1 Yes	2 No
certificate rector, pag	B	25. Was case referred to medical examiner?	Hospital:				Other		Check only o			
ral dir	7	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpar		ER/Outpatier 28b. Time o		4 🗆		e 5 ☐ Resid		Other (Spe	cify)
After	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	lay Year)	Injury		Injury at Work? 1 Yes 2					
ral Director: led in by the	Certification:	3 Suicide 6 Could no 4 Homicide determine	be 28e. Place of I	njury - At h etc. (Speci	iome, farm, sti fy)	reet, factory, of	fice	28	If. Location (S City or Tow			ural Route Number,
o the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)  1 • Certifying 2   Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred at the vestigation, in i	ne time, date ny opinion, d	and place, and leath occurred	d due to the d at the time, d	cause(s) a date and	and manner as place, and due	s stated, to the cause(s)
To the complet	Me	29b. Signature and title of certifier	3 thesha	18		29c. Li	anse numbe				signed (Mont	
Ju	5	30. Name and address of person who John B. Theoba									20	010
Sta		31. Date filed (Month, Day, Year)	■2. Regis	trar's Sign	ature						,	
Registr		JAN 2 0 200	4 Blown	, M.	Appa	w						
17 Rev 1/2	001		_									

			For State Registrar	State of	f Marylar	•			lealth a Death		ental Hy	giene Reg. No	20		06062
		П	1. Decedent's Name (First, Middle, L	ast)							2. Date of De	ath Da	v	Year	3. Time of Death
	Physici /Medic		DOREATHER G. TO	IEY			,		<u> </u>		JANUAR				12:00P M
)	Examin		4a. Facility Name (If not institution, g.	ve street and nun	nber)		4b. City,	Town, or	r Location of	of Death		40	. County o	of Death	
			PRINCE GEORGES I		/		16 Linda	CHE 1 Year	VERLY		0 D-1(D)				EORGES
	Funeral			Sex 1□M XŽX F	7. Age (In yrs.	Ven	Months	Days	Hours	Min.	8. Date of Bir (Month, Da			Cour	
	Director		Usual Residence of Decedent		8	34 Trs.					NOV. O	0 · 1	919	500.	TH CAROLINA
	yland now		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							1	0d. Inside City Limits
	Man	tor	DC		WA	SHINGT	ON								XM☐Yes 2☐No
	th the	Directo	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of W	hat Cour	ntry?
	23a		4127 MINNESOTA	AVE. NE				200	19			UNIT	ED S		
	r des	Funeral	11. Marital Status	12. Was Dece Armed For	rces?	J.S. 13.	Was Dece	dent of H cify Cuba	ispanic Ori an, Mexican	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	o-		- Americ , White,	an Indian, etc.
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 Tes \( \) If Yes, Giv Year or Da	2X No e		1 □ Yes X	<b>3</b> □ No	Specify:				Specify:	BLA	CK
5-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23s or 28s-f show svent, Ite Medical Examicar must be redified at	ed t	15. Decedent's		1105.	16a. Dece	dent's Usu	al Occup	ation			16b. K	ind of Bus	siness/Inc	dustry
215	in 72	Completed	(Specify only highest g	rade completed)	45-)	(Give	kind of wo DO NOT u	rk done d	during most	t of worki	ng				,
212	iene.	E	Elementary/Secondary (0-12) 5TH	College (1	-40f 5+)	Н	OMEMA	KER							
D	othe othe	Be C	17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame	)	
<u>a</u>	should be nd Mental marked o	To B	JOHN HENRY GLADDI	EN					TAMME	ER SE	IIRLEY				
Maryland 21	s 1 and 2 should if Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rura	I Route Numb	er, City o	or Town, S	itate, Zip	Code)
Σ.	and and and a saith		LINDA MARTIN / DA	UGHTER_		4127			AVE.		WASH				
altimore,	ges 1 t of Hi if Iter or oth		20a. Method of Disposition  XXX Burial 2 ☐ Cremation 3	☐Removal from S	1	Place of Dispo cemetery, crea	osition (Nai matory or c	me of other plac	(6)	L	ate	20c. Lo	ocation - C	City or To	wn, State
E	nit. Peges artment of ortant: If It injury or o		* 4 □ Donation 5 □ Other (Spec	ify)		MONY M				-	described to the second				
Ball	permit. Peg Department Important: eny injury ence.		21. Signature of Funantil Sarvice Lic	nsve	Ill						HOME O				
	40 E • 0		OS Part 5 arts disease or so	malications that or	oursed the dear				AND R				, MD	2074	46 Approximate
			23a. Pert1. Ent r the disease, or co shock, or eart failure. List on	y one cause on e	ach line.	un. Do not en	ter the mot	ie oi dyin	ly, such as	Cardiac	respiratory a	111651,			Interval Between Onset and Death
E	Pnysician /Medical		Immediate Callie (Final disease or combition resulting in death)	α.	AC ARR		A							$\perp$	
3	Examiner				or as a consec			DIGE	AGE						
	* .	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ROSCLER or as a consec		EART	DISE	ASE					-	
	uted ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events												
Ć.	execting and and rial-tra	Еха	resulting in death) Last	Due to (	or as a consec	quence of):									
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical		d											
89	ntifica ng ph as th	Ned	IF FEMALE:												
Box	eath certific attending p	an/I	23b. Was decedent pregnant	23c. If yes, out 1□Live b	come of pregn irth 2 ☐ Feta		∃Ectopic p	regnancy	,				23d. Date Mont		Day Year
	e dea the at	Physician/Me	in the past 12 months? 1 ☐ Yes 2XXNo 9 ☐ Unknown	4∐Pregna 9∐Unkno	ant at time of o	death 5	Other (sp	pecify)							<b>54</b> ,
0.	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions	contributing to de	ath but not re-	sulting in the r	inderlying (	anse and	en in Part I		23e Did i	obacco s	use contril	bute to th	e cause of death?
Š,	The law requires that the tte has been signed by th page 2 should be detache	l by	Talen. Other signment contains	continuously to do	att bat not ro	Summy in this a	industrying C	acoo givi	on are die.	•		Yes X			ably 4 □Unknown
000	w require been si should b	Completed											1,1721 2	235 L	1028 5553
3ec	e law has l	Idm									24a. Was		pr de	or to coreath?	psy findings available apletion of cause of
a			05.14		_						1 Yes		10	Yes	2□ No
Division of Vital Records,	Attending Physicien: r death. sctor: After this certifica by the funeral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ¾XNo	Hospital:	npatient 2	] ER/Outpatie	nt 3 D	Oth			ne 5□Resi		e ClOtha	/Specific	a
ō	Phy r this aral d		27. Manner of Death	28a. Date o	of Injury	28b. Time o		28c. Injun Worl			28d. Describe				0
O	tanding I leath. tor: After the funer	ation	MXNatural 5 ☐ Pending 2 ☐ Accident investigate		h, Day Year)	Injury	М		k? Yes 2⊟i	No					
NIS.	I or Attandi after death Director: A In by the fi	ifica	3 ☐ Suicide 6 ☐ Could not determine	d 289. Place	of Injury - At h	nome, farm, st	reet, factor	y, office			28f. Location ( City or To	Street an	nd Number	r or Rura	l Route Number,
	tal or At s after d el Direct ed in by	Certification;	4 E Homodo	Dulidii	19, etc. (5peci	· y /					Ony or 10	mi, otale	,		
	To the Hospital or A within 24 hours after To the Funerel Directorpletely filled in by	edical (	29a. Certifier XIX Certifying F	Physician: To the aminer: On the ba	best of my kn	owledge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the	cause(s)	and man	ner as st	ated.
	To the He within 24 To the Fu	ledi	one)	and manr	er stated.										
	To the within To the comple	Σ	29b. Signature and title of certifier		X		29		o number	10	_	29d. Da	/	,	Day, Year)
0	(		1 ( )	- de	Du	2			/ / 3	ഗ			1/	20	107
(	(3)		30. Name and address of person wh					T 177	OTTE	7777777	V 347				
			EDGAR POTTER, N 31. Date filed (Month, Day, Year)		31 egistrar's Sign	HOSPIT	AL DR	TVE	CHE	VEKL	Y, MD				
	Sta Registr		JAN 2 2 200			low	20								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0930 AM VARGAS 16,2004 HOSARIO 0 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOSPITAL PACK MONTEONETH TAKOMA ADVONTET MASHINGEN If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min. Months 1 □ M 2 X F SEPT.16,1931 72 **ECUADOR** Director 220-82-7263 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b, County Itame 23a or 28a-f ehow Examiner must be notified at 1 XYes 2 □ No Director MONTGOMERY ROCKVILLE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with t Funeral 4806 ASPEN HILL RD. 20853 U.S.A. death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give filed within 72 hours after 1X Never Married 2 ☐ Married Specify: ECUADORIAN ò Baltimore, Maryland 21215-0036 1 XYes 2 No þ 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: 'natural', Completed The Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than 6 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event page. Be VARGAS JOSE I. ROSA M. GARZON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ASPEN HILL RD., ROCKVILLE, MD. 20853 DORA VARGAS/SISTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition BASILICA NAT L. SAGRADO COROZON CFMETERY 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 1-30-2004 OUITO, ECUADOR 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GESPIRATOLY /Medical Due to (or as a consequence of): **Examiner** DISTURS SYNDROME LESPIKATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner 2 1/2 MOUTHS or Attending Physician: The law requires that the death certificate be executed burial-transit INFACCTION MYOCARDIAL and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has med? 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 X Inpatrent 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier GM-ce. (e D50590 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) M.D., 7610 CARROLL AVE. #400, TAKOMA PARK, Md JONATHAN CALUKE 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 0 2004

Registrar

		1	For State Registrer	State of Maryland		rtment of Heal			ene 20		03964
m			Decedent's Name (First, Middle, Last)					2, Date of Death Month	Day	Year	3. Time of Death
	Physici		Viola	Wong				January			5:40A <sup>M</sup>
,	/Medic Examin		le. Fecility Neme (If not institution, give str			4b. City, Town, or Loca	ation of Death		4c. County of	of Deeth	
	_ Xu	Ĭ	Montgomery Genera	al Hospital		01ney			Montgo		
	Funeral	5	5. Social Security Number 6. Sex	7. Age (In yrs. la			Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, )	(ear)		ace (State or Foreign try)
	Director		192-26-7224	100	O Yrs.			Dec 24,	1903	Cali	fornia
	pue *	<u> </u>	Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	lanyla e ho				C - 1 1 7 7 6	er Spring					1 ☐ Yes 2 ☐ XNo
	28a-1	Director	Maryland Montgot	mery	STIVE	10f. Zip Code		10	g. Citizen of W	hat Coun	try?
	Mith Sa or	ā	3330 N. Leisure	World Blvd. #	716	20906		į	USA		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Madical Examinar mast te maillisd at	Funerai		2. Was Decedent Ever in U.S	. 13. V	Vas Decedent of Hispar	nic Origin? (Spe	cify Yes or No-		- America	
0	or Iter	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐XNo	İ	f Yes, specify Cuban, M I □ Yes 2t <mark>%</mark> No <i>Si</i>		nican, etc.)	Specify:		atc.
3	ral', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 1 1 es 2 2 1 1 e 0 3 j				Asi	
ဂ္ဂ	natur	Completed	15. Decedent's Education (Specify only highest grade)		(Give	lent's Usual Occupation kind of work done during	g most of worki		6b. Kind of Bu	siness/Inc	dustry
9500-61212	ithin	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	1 +-		Tn	surar	100
	Hygier Hygier other th	S -	47. Exhadables a /First Middle   get)	2		Life Un		(First, Middle, Ma			ice
ב	ould be fi Mental H arked ot atic ever	œ l	17. Father's Name (First, Middle, Last)							,	
2	should be filed within 72 hours after death with the Marylan nd Mental Hygiene, marked other than "natural", or Items 23s or 28s-f show marked other than "natural", or Items 23s or 28s-f show marke ovent, the Medical Examinar than near the multipled at	၉	T. Wah Hing  19a. Informant's Name/Relationship (Typ)	e Print)	19b Mailin	ng Address (Street and I	Mon Son Number or Rura		City or Town,	State, Zip	Code)
Maryland	d 2 sl th an 7 is r traus					0 Berkshir					
ص ف	1 an Heel em 2	-	Geraldine Wong/D  20a. Method of Disposition	20b. Pla		sition (Name of natory or other place)			Oc. Location -		
Baltimore,	ages int of t: If i		1 N Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	amoval from State		n Cemetery	Jan 2	4. 2004	Sacra	ament	co, CA
=	artme artme		21. Signature of Funeral Service License		22	. Name and Address of	Facility Hin	es-Rinal	di Fun		
B	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If item 27 is marked any injuguer other traumatic epoce.	1 1	aland	Domuel	13	1800 New Ha	mpshire	Ave, Si	lver S	pring	g, MD 20904
0,	Physician /Medical Examiner phi/sician and phi/sician and phi/sician and phi/sician site phi/articles and phi/sician site phi/	Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on the control of	Due to (or as a consequence of the orange)  Anem (C)  Due to (or as a consequence of the orange)  Due to (orange)	ence of):	infarce	lure	in ospiratory arros		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Approximate Interval Between Onset and Death  ### CG   C
P.O. Box 68760,	that the death certificate bed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[	Ectopic pregnancy Other (specify)			Mor		Day Year
	Se C 90	þ	Part II. Other significant conditions con	tributing to death but not resu		nderlying cause given in	n Part I.				ne cause of death?
I Records,	The law requires are has been sign page 2 should be	Completed	hypertensi					24a. Was an autopsy perform	ed?	Vere auto prior to co leath? Yes	psy findings available mpletion of cause of
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	ospital:		Othor	J. C. C. C. C. C. C. C. C. C. C. C. C. C.	h (Check only one			
of	hysic this c	ြို	1 Yes 2 No	1 Ninpatient 2 □ I	ER/Outpatie 28b. Time o	Nt 3 DOA		me 5 Resider 28d. Describe hor			y)
й	ding P h. After funera	i o	27. Manner of Death  1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work?	2 🗆 No	200. 0030100 110	w injury cocum	00	
Division	a a a	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify				28f. Location (Str. City or Town,		er or Rura	al Route Number,
	To the Hospital or Atterwithin 24 hours after de To the Funerel Directo completely filled in by the	edical C	29a. Certifier (Check only one) 2 Medical Exemir	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	th occurred at the time, overstigation, in my opinion	date and place, on, death occur	and due to the ca red at the time, da	use(s) and ma te and place, a	nner as s and due to	tated. the cause(s)
	To the Within 2 To the comple	Mec				29c. License nu	ımber	29	d. Date signed	(Month,	Day, Year)
	G		1/1/	al no	0	0500	612	,-9	anvan.	, 19	1,2004
	70		30. Name and address of person who co	impleted cause of death (Item	23a) (Type.	. Print)			1111-0113	, ,	1
	S.	ate	31. Date filed (Month, Day, Year)	7 A L L G/2 32. Registrar's Signa	LEISU I	E WORLD	m COKA	-C CGW 78	2 5/10	er Spri	ns Mary los
	Regist		JAN 2 0 200	04 Jenewa	19	sporks	4				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 11, 2004 **Physician** 1625 REVA L. WOLK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 09/21/1918 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F 85 Director 292-16-9891 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County Itams 23a or 28a-f show the Medical Exercites must be notified at 1 Yes 2 □ No Director SILVER SPRING MARYLAND MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With U.S.A. 3310 N. LEISURE WORLD BLVD. #618 20906 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Ñ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ital may injury or other traumatic event, the Mucdeal Exercities any injury or other traumatic event, the Mucdeal Exercities any injury or other traumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROSENBERG ROSE LUPER ပ LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FIELDS ROAD #1805, GAITHERSBURG, MD 20878 9701 STANLEY E. WOLK/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM. GARDENS 01/13/2004 OLNEY, MD 21. Signature of Funeral Service Licensee DANZANSKY 1170 ROCK e and Address of Facility NSKY-GOLDBERG MEMORIAL CHAPELS, INC. ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) adu **Physician** /Medical Due to (or as a consequence of) Examiner + ltorosol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months?
1 Yes 25 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Obstructive biscase 4 Unknown 1 🗌 Yes 2 🗌 No 3 Probably Slanosia no 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 XNo 24a. Was an autopsy performed page 2 umoria certificate 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2000 1 Dinpatient 1 Yes 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7070 G 2004 Hampshire 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 751 } New 20912 Q(50J/ 5005W166 Mark 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 20 2004 Registrar

			For State Registrar	State of Ma	ırylan	•			lealth a		ental Hy	/gien Reg. N	1111		00966
			Decedent's Name (First, Middle, La	est)	-						2. Date of De	eath			. Time of Death
п	Physici		MARION S. WOLFSON	ſ							Month JANUAR		ау Yea , 2004	ır	9:30 P M
	/Medic Examin		4a. Facility Name (If not institution, gir				4b. City	, Town, or	r Location				c. County of Di	eath	
			15301 WALLBROOK C	T. #3F			SILV	ER SE	PRING			Mo	ONTGOME		
	Funeral				(In yrs.	last birthday)	If Unde Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of Bi (Month, Da	rth ay, Yea	9. E	Birthplece Country)	(State or Foreign
10.	Director		011-08-8086	1□M 2\\ F	8	5 Yrs.				Ф	6/14/1	918	MA	INE	
	p s		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d.	Inside City Limits
	sho	ō		ID.		•									1 X Yes 2 □ No
	28a-1	Director	MARYLAND MONTGOME  10e. Street and Number	RY	SILV	ER SPR		ip Code				10a. C	itizen of What	Country'	?
	with with			um #ar				20904				U.S		,	
	ne 23	Funeral	15301 WALLBROOK C	12. Was Decedent I	ever in U	.S. 13.				igin? (Spec	offy Yes or No lican, etc.)		14. Race - A		
·0	fler of the control o	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ⚠	lo						ican, etc.)		Black, W	hite, etc.	
ဗ္ဗ	al', o	by	3 \ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	261 No	Specify:				Specify:	WHI	TE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ha Madical Examinal minal be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	kind of w	ork done	during mos	t of workin	a	16b.	Kind of Busine	ss/Indus	try
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT	use retired	1)		-		WISH CO		L
2	Hygier Hygier Ather th		12			SECRE	TARY	-	10 Moth	ada Noma	(First, Middle		OR AGIN	G	
Maryland	be fill H off	Be	17. Father's Name (First, Middle, Las JULIUS	COHEN					DORA	ers mame (	(FIISI, MIGGIE		AGOFSKI		
$\frac{2}{5}$	1 Mer narke	P L				10b Maili	ne Addro	s (Street		or or Quest	Pouto Numb		or Town, State	Zin Co	del
Na Na	d 2 sh h and 7 is n traun		19a. Informant's Name/Relationship												
	1 and Health em 27 ther to		JAY E. WOLFSON/SC	'IN	20b. F	lace of Dispo	sition (Na	ame of		Da			MARYLAN Location - City		
ğ	Pages nent of int: If its		1 ☐ Bunal 2 ☐ Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Special			emetery, cre	-	-	1	1/19/	2004	TEAT	T.C. CHILI	CII	VIDCINIA
Baltimore,			21. Signature of Funeral Service Lice		NA	FIONAL 22				1/12/ tv				iun,	VIRGINTA
Ba	permit. Departr importa any inji		1 (Imanda >	udouno		ED	WARD	SAGE	L FU	MERAL	DIREC	TIO	N, INC. E, MD 2	N852	
	£		23a. Pert1. Enter the disease, or con	nplications that caused	the deat								ے ۱۹۱۷ و	Ap	proximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final			D								Or	erval Between iset and Death
A	Physician /Medical		disease or condition resulting in death)	a. BREAST C							<del></del>			YEA	
Н	Examiner		1		,										
**		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):									
	cuted	Examiner	that initiated events	c											
o,	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):									
8760	± × •	lical		d										-	
89	The law requires that the death certificat tie has been signed by the attending phy tage 2 should be delached for use as th	Physician/Med	IF FEMALE:	00 1	4										
Вох	ath cattered or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fete	Ideath 3		pregnancy				ĺ	23d. Date of o Month	delivery Da	y Year
o.	the 2	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time or u	eath 5L	Other (s	феспу)							
α.	that the de ted by the a detached t	P.	Part II. Other significant conditions	contributing to death be	ut not res	ulting in the u	nderlying	cause giv	en in Part I		23e. Did	tobacco	use contribute	lo the c	ause of death?
Records,	sign sign d be	d by									10	Yes :	2 X No 3 □	Probably	4 Unknown
Ö	w requir been si should	Completed									24a. Was	an	24b. Were	autopsy	findings available
Re	he law s has ge 2 s	m d									auto perfe	psy ormed?	prior t death	o comple?	etion of cause of
Vita	ician: Th certificate rector, pag		25. Was case referred to medical						26 Place	of Doath	1 ☐ Yes (Check only	2½ N	0 1 L Y	es 2	] No
	Physician: rthis certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2 🗆	ER/Outpatier	nt 3[][	OA Oth	or				6 ☐Other (Si	necify)	
ō	tending Physician: The leath.  tor: After this certificate hathe funeral director, page	<b> -</b>	27. Manner of Death	28a. Date of Injui		28b. Time o		28c. Injun	y at		Bd. Describe				
<u>o</u>	Attending For death.  ector: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigate		rear)	Injury	м	Worl	Yes 2 🗆	No					
Division	or Attendate death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determined		iry - At he	ome, farm, str	reet, facto	ry, office		28	3f. Location ( City or To		and Number or	Rural Ro	oute Number,
	s afte	Cert		Danieling, Cit	. (Opcon	,,									
	Hospital 24 hours 2 Funeral I			hysicien: To the best on the basis of the basis of											
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one)	and manner sta						coodinat					
	With To	Σ	29b. Signature and title of certifier				2:	9c. Licens	e number			29d. D	ate signed (Mo	ntn, Day	, rear)
7	10		I have y	me				D424	52			JANU	ARY 12,	200	04
			30. Name and address of person who												
			CHITRA RAJAGOPAL,	M.D., 181		RINCE	PHIL	IP DE	R. #32	27, 01	LNEY,	MD_2	20832		
	Sta Registr		31. Date filed (Mooth, Day Year) 2 1		المراوسين	B	20	acks	1						

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 17, 2004 Physician John H. Wolfe 2:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Yrs. 89 483-05-3375 Feb. 19, Director Iowa Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral', or itams 23a or 28a-f ahow Examiner must be notified at 1 Yes 2 No Chevy Chase Maryland Montgomery Direct the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With 5480 Wisconsin Avenue #825 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
ante if item 27 is marked other than "natural", or iten
ury or other traumatic avant, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Grocery Store 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Loren Wolfe Helena Doerning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pearl V. Wolfe/Wife 5480 Wisconsin Ave., #825, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date January 21, Silver Spring, Maryland O H P 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/ Chase, Inc. M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Hemorrhage **Physician** Intracranial unknown /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 I Inknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) Barker House MD January 18, 2004 D0059871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Hovemo agoi Medical Center Drive Rockville MO 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2004 Registrar

		. For			ent of Health and		
		1 - State Registrar		Certific	ate of Death	Reg.	No. 6004 009
Physici	an	1. Decedent's Name (First, Middle, Las	,	Winst		2. Date of Death Month	Day Year . 3. Time of Dea
/Medio		myarilyn				Jan/	6 2004 0835
Examir	ner	4a. Facility Name (If not institution, give		4b. (	City, Town, or Location of De		4c. County of Death  Monte omerica
<u> </u>		5. Social Security Number 6. Se	X 7 Age //n s	vrs. last birthday) If U	nder 1 Year   If Under 24 H		
Funeral Director			_M 2⊠F 6.	Mon			ear)  PA  Sirthplace (State or For Country)  PA
natural', or Items 23a or 28a-i ehow dical Examiner must be notified at		10a. State 10b. County	10c.	City, Town or Location			10d. Inside City Lin
rat', or items 23a or 28a-f ehow Examirer must be notified at	to	MD Montgome	rv	ilver Sprin	α.		1 □ Yes 2 🙀
r 28a	Director	10e. Street and Number			Zip Code	10g.	Citizen of What Country?
33 0	O E	114 Eldrid Dr.		2	0904	II	.S.A.
8	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. Was D	ecedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,
"natural", or Items olical Examiner ma	/Fu	1 ☐ Never Married 2 🙀 Marned	1 ☐ Yes 2 ☑ No If Yes, Give		specify Cuban, Mexican, Pu s 25th No <i>Specify:</i>	erto rican, etc.)	Black, White, etc.
Je J	d by	3 Widowed 4 Divorced	Year or Dates:		S ZONINO SPECITY.		Specify: White
piene. r then "natur Ine Medicel	Completed	15. Decedent's Edi (Specify only highest grad		16a. Decedent's l (Give kind or	work done during most of w	vorking 16b	. Kind of Business/Industry
the sa	E D	Elementary/Secondary (0-12)	College (1-4or 5+) 4		T use retired)		N C A
H the		17. Father's Name (First, Middle, Last)	4	Analyst	18 Mother's N	ame (First, Middle, Maid	N.S.A.
te d	) Be	Harry Crum				e Bitting	Jen Sumame)
th and Menta 7 Is marked traumatic ev	ဥ	19a. Informant's Name/Relationship (T	roe Print)	19h Mailing Add			ty or Town, State, Zip Code) 2090
		S. Dennis Winste		3404 Ham	npton Hollow	Dr. Apt. A	Silver Spring, MD
Head Head		20a. Method of Disposition	201	b. Place of Disposition /	Name of		Location - City or Town, State
tent: If its jury		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		cemetery, crematory oundon Parl			
# = E mi		21. Signature of Funeral Service Licens		The second secon	and Address of English		altimore, MD
Departr Import any inj		I aluque a	Cuple			Hines-Rinal	di F. H. <u>ver Spri</u> ng, MD 209
nysician Medical xaminer	ıer	if any leading to immediate	Due to for as a cons	sequence of):	cardial In		Interval Between Onset and Death
physician and the burial-transit	dicai Examin	causé. Enter Underkying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):			
ed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 100 □ Unknown	etal death 3 ☐Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
igned by be detac	by Ph	Part II. Other significent conditions co	ntributing to death but not i	resulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ite has been signed by the attending phoage 2 should be detached for use as the						1 ☐ Yes	2 No 3 Probably 4 Unkno
ate has been si page 2 should l	Completed					24a. Was an autopsy performed	
certificate rector, pag	Be (	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	12 103 22 110
his co I dire	2	1X Yes 2 No	lospital: 1 🗆 Inpatient 2	□ ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
fter t		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
or: A	cati	2 Accident investigation		М	1 Yes 2 No		
within 24 nouts arter death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Ai building, etc. (Spe	t home, farm, street, fac ocify)	tory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
thin 24 hours a the Funeral I mpletely filled	Medicai	29a. Certifier (Cneck only one)	ter: On the basis of exami	knowledge, death occurrination and/or investigat	ed at the time date and laction, in my opinion, death occ	e. and due to the cause curred at the time, date a	(*) and manner as stated and place, and due to the cause(s)
within To the comple	Mec	29b. Signature and title of ceptifier	and mailner stated.				
3 ± 8			1	DME	29c. License number	29d. (	Date signed (Month, Day, Year)
Y	- 4	30. Name and address of person who co	CK J F3	USITE	5	- A - 19-	n 16, 2004
	İ	30. Name and address of person who co	mpleted cause of death (II	tem 23a) (Type, Print)	5101 MET	acal Park	DI
	/2	2RR N BKE  31. Date filed (Month, Day, Year)	CHER, MC	OME	Bilves Sp.	ring m	V 20903
Sta Registra		.IAN 2 0 2004	32. Registrar's Sig	mature & So	ands		

			State of Maryland		of Health and r		eg. No.	04 03969		
		1. Decedent's Name (First, Middle, Las	1)			2. Dete of Dear	th	3. Time of Death		
	Physician	Richard Ne	ewell Williams			Januar				
	/Medical	4a Fecility Neme (If not institution, give			4b. City, Town, or L	ocation of Death	4c. County o	of Deeth		
	Examiner	Hillhaven Nur			Adelphi		Prince	e Georges		
	Comment	5. Sociel Security Number 6. Se	7. Age (In yrs. I	last birthday) If Under Months	1 Year If Under 24 Hrs. Deys Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)		
	Funeral Director	293-16-8134	XM 2□F 79	Yrs. Months	Soyo Hours Hill.	Dec. 5	,1924	"Ohio		
		Usuel Residence of Decedent						10d. Inside City Limits		
9	Pos an	10e. State 10b. County		y, Town or Location				1 ☐ Yes 2 ☐ Yo		
1	to To	MD Prince C	Georges Ac	delphi						
4	ter ceam with the warylank terms 23a or 23e-f show ingremment be notified at -uneral Director	10e. Street and Number		10f. Zip		1	10g. Citizen of Whet Country?  USA			
	23 E	3210 PowderMill	Road		20783					
-	r items 23 direct must Funeral	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Deced	lent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Hace Black	, White, etc.		
ا ج	F F F	1 ☐ Never Married 2 ☐ Married	1 ☑Wes 2 ☐ No	1□ Yes			Specify:	White		
2	refr, o	3 XWidowed 4 □ Divorced	Yeer or Detes: 1943	or Detes: 1943			16b. Kind of Bus			
6	natu natu plical	15. Decedent's Ed (Specify only highest gra	lucetion de completed)	16e. Decedent's Usua (Give kind of wor	il Occupation ik done during most of wor se retired)	rking	IOD. AING OF BUS	giilodariildadiy		
71213-0020	ed within 72 ho ygjene. ver than "natur rt, tre Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ninist		Newsp	paper		
V .	tiled within 72 hours after daam with the maryland Hygiene. Hygiene. ant, the Medical Evantiner must be notified at e Completed by Funeral Director	17. Fether's Name (First, Middle, Last)		ı macı		ne (First, Middle,	<u> </u>			
ב כ	a g g a				1	la Powe				
	should to and Ment marked umatic	Fred Williams	Tuno (Print)	19h Mailing Address	(Street and Number or Ri			State, Zip Code)		
	N	19a. Informant's Name/Reletionship (								
	and taalth m 27 her tu	Brian Williams, S	0N 20h F	Place of Disposition (Nar emetery, crematory or o	om Dr. Damo	Date Date	20c. Location - (	City or Town, State		
o i	Pages 1 nent of H int: if Ite	1 ☐ Burial 2 🕱 Cremation 3 ☐				1/12/0/		ndria, Virginia		
	tant:	4 □ Donation 5 □ Other (Specifi			Crematory					
Baltimore,	permit. Pages 1 and Department of Haalt Important: if Item 2: any Injury or other DAGG.	21. Signature of Funeral Service Licer	Del st	1205 E	d Address of Fecility Old Belle Haven	a Town Rd. Alex	runerai kandria,	Virginia 22307		
		23a. Pert1. Enter the diseese, or com	plications that caused the deat	h. Do not enter the mod	le of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between		
No.	Physician	shock, or heart failure. List only	one cause on eech line.					Onset and Death		
ya <sup>3</sup>	/Medical	Immediate Cause (Final	ALZHEIME	R'S DISEA	I S E					
F	examine:	resulting in death)  Due to (or es a consequence of):								
	outed nd ransit	Sequentially list conditions.	b. Due to (c							
'n	an an rial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Disease or injury c.								
8760,	requires that the death certificate be executed been signed by the attending physician and thould be detached for use as the burial-transit effect by Physician/Medical Examiner	Ceuse (Disease or injury that initiated events								
89										
ŏ	v requiras that the death certific been signed by the attanding t should be detached for use as letted by Physician Me		d				1			
n	deatl	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did	tobacco use cor	ntribute to the cause of death?		
Ö	t the by the tache	HYPERTENSIO				10	Yes 2X No	3 ☐ Probably 4 ☐ Unknown		
ď.	as that igned t be det	HYPERIENSION	V, CORONARI	MILITERIA				0.0		
of Vital Records, P.O. Box	quira an sig	LOWER GASTR	OINTESTINAL	BLEEDING		24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause		
O O		LOWLK GASTK						of deeth?		
R	The law require pate has been signated begins page 2 should Completed					10	Yes 2X No	1 ☐ Yes 2 ☐ No		
ta	l or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2	25. Was cese referred to medical			26. Place of De	eath (Check only	опе)			
5	Physician: rthis certific aral director,	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ D	OA Other: 4 Nursing	Home 5□ Resi	dence 6 □Oth	er (Specify)		
	or this eral c	27. Manner of Deeth	28e. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe	how injury occur	red		
o	Attending r death. ector: Afte by the functional filestore	1 XNaturel 5 ☐ Pending 2 ☐ Accident investigetion	, ,	M	1 ☐ Yes 2 ☐ No					
Division	Atter r dea bctor by the	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, facto	ry, office	28f. Location ( City or To	Street and Numb wn, State)	per or Rural Route Number,		
á	tal or Attending Pi rs aftar death. al Director: After ti led in by the funera	4 Homicide								
	To the Hospital or within 24 hours afte To the Funeral Dir. complately filled in		hysician: To the best of my kn miner: On the basis of examin and manner steted.	owledge, death occurred ation end/or investigation	d at the time, date and plea n, in my opinion, death occ	ce, end due to the curred at the time,	ceuse(s) and ma date end place,	anner es stated. and due to the cause(s)		
	thin 2 the mpla	29b. Signature and title of certifier	and marinor stotod.	2	9c. License number		29d. Date signe	d (Month, Day, Year)		
		230. Signature and title of certified	11		D55559		January	y 13,2004		
	18	100	W		פנכנע			, -,		
		30. Neme end eddress of person who			onton Daire	Croonh	alt MD	20770		
		Thomas E. Masle 31. Date filed (Month, Day, Year)	2n, MD /525 G 32. Registrer's Sign	neture .		Greenb	CIL MID A	20110		
	State Registra	1881 9 9 20		& So	nels					

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 **Physician** Camilla S. Williams 2004 10:424bm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Rockville Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day. 01/29/ 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2√2F Georgia 66 258 64 5852 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location rat', or itame 23a or 28a-f ehow Examiner must be notified at Gaithersburg Md Montgomery 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20878 405 Bostwick Lane Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Black Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates 'natural', al Hygiene. d other then "natural event, Ira Mudical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Supervisor 1 + rmit. Pages 1 and 2 should be filed v spartment of Health and Mental Hygie portant: if Item 27 Ie marked other t iy injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rose Bud Smith Eddie Simmons 2 Husb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) and 405 BostwicLane Gaithersburg, Md 20878 Henry Lee Williams SR 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/26/04 Brentwood, Md permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySnead Mortuary Service, P.A. 21. Signature of Funeral Service Licenses 1409 Fairlakes Pl Ste B Mitchellvillie, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Pounty neuro endocrino Physician 3 week Metastalic resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medical the ass attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 2No Division of Vital Records, P.O. detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No 1 Inpatient P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending Natural М 1 ☐ Yes 2 ☐ No death. investigation n 24 hours after death.

• Funeral Director: A letely filled in by the for 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide † Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Functional 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 201 128262 Jan 22, 2004 ND 330 Rockulle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD MENDHIRATT 2401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 23** ack. Registrar

									d Mental Hyg	-	lible.	
			1 - State Registrar		, ,		rtificate of			Reg. No.	UO4	03971
	Physici	20	Decedent's Name (First, Middle, L.	ast)					2. Date of Dea Month	ith Day	Year	3. Time of Death
1	/Media	al	Mary Louise We						Januar	y 21, 2	2004	6:00 a <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, g			ntor	4b. City, Town, o		eath		ty of Deeth	
-	Funeral		Holy Cross Reha 5. Social Security Number 6.	Sex 7.		last birthday)	If Under 1 Year	If Under 24 l	Irs. 8. Date of Birt		o. Birthp	place (State or Foreign htry)
	Director		464-28-0900	1 □ M 2 🔀 F	91	Yrs.	Months Days	Hours N	lin. 8. Date of Birtl (Month, De) Jan. 2,	1913	Texa	
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sh	tor	Maryland Princ	ce George	s	Laure	1					1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	s 23s	ral	14004 Barkham Co		F i- 11	6 40	20707		10 11 11		SA	
	fter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Forc 1 ☐ Yes 2	as?	.5.	If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Ha Bla	ice - Americ ack, White,	
93	ours a	þ	3   Widowed 4 □ Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2 ☑ No	Specify:		Speci	ity: Whi	Lte
5	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show the Modical Exterities fraint be notified at	Completed	15. Decedent's (Specify only highest g	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of 8	Business/In	dustry
12	withir ene. then	duo	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>DO NOT</i> use <i>retired</i> emaker	3)		Own	Home	
g	al Hyg other	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother's h	Name (First, Middle,			
ylar	Menta Menta arked	To	John Agui						a South P	***		•
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship						Rural Route Number			Code)
ē,	Healt tem 2 other		Peter Wedderburn  20a. Method of Disposition	1/ 5011	20b. F	Place of Dispo	sition (Name of	1	Laurel, I	20c. Location		wn, State
E O	Pages nat: In		1 ☑ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spec		Ga Ga	te of l Cemet	matory or other place Heaven	Jar	nuary 24 2004	Silver	- Smrt	n, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Modical Extratriat result be notified at once.	П	21. Signature of Fundral Service Lic	ensee		22	Name and Addre	ss of Facility	s Funeral	Home 1	. opii	ing, rib
	205 2 2	Y 10		Sily			<u> Univer</u>	sity Bl	vd. W., S:	ilver S	Spring	, MD 20901
4			23a. Part1. Enter the disease, or conshock, or heart failure. List online Immediate Cause (Final	y one cause on eac	h line.	n. Do not ent	er the mode of dyin	ig, such as card	liac or respiratory arr	est,		Approximate Interval Between Onset and Death
?	Physician /Medical		disease or condition resulting in death)	a. Dement	ia as a conseq	uence of):						5 years
н	Examiner		Sequentially list conditions	b								
	pe sit	ulnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):						
<u> </u>	te be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):					-	
1760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	cal	•	d								
x 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE:									
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		me of pregna n 2 ☐ Fete it at time of d	I death 3	Ectopic pregnancy Other (specify)				ate of delive onth	ry Day Year
P. 0.	the d	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		6E(I) 5	TOTHER (Specify)			Africa Comment		
S, G	res that igned b	by P	Part il. Other significant conditions	contributing to deat	h but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	acco use con	tribute to th	e cause of death?
ord	w requir	eted							1 TY	es 2 No	3 Prob	ably 4 Unknown
Vital Records,	has b	Completed							24a. Was a autops perforr	y	Were autop prior to con death?	osy findings available inpletion of cause of
<u> </u>		e Co	25. Was case referred to medical					26. Binn of F	1 ☐ Yes 2	2 ⊠ No	1 Yes	2 No
<u> </u>	S .2 5	ToB	examiner? 1 □ Yes 2 🙀 No	Hospital:	atient 2	ER/Outpatien	t 3 DOA Othe		eath <i>(Check only on</i> Home 5 🗌 Reside		ner (Specify	·)
Division of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I (Month,	njury Da <i>y Year)</i>	28b. Time of Injury	Worl	at c?	28d. Describe ho			
Sic	l or Attending after death. Diractor: After in by the funer	licat	2 Accident investigation 3 Suicide 6 Could not	be 380 Place of	Injury - At ho	ome farm stre	M 1 ☐ ' eet, factory, office	Yes 2 □No	28f. Location (St	reat and Numi	har ar Pum	Pouts Number
<u>≥</u>	- e e	Certification:	4 ☐ Homicide determine	building	etc. (Specify	()	out, ractory, office		City or Town		Jer or Hurar	noute Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (	29a. Certifier 1⊠ Certifying P (Check only one) 2 ☐ Medicel Exe	Physician: To the be eminer: On the basi and manner	s of examina	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)
	To the To the comp	W	29b. Signature and title of certifier	1 0			29c. License	e number	2	9d. Date signe	d (Month, L	Day, Year)
	15		· fanen		<i>=</i>	5	D43	237		January	22,	2004
			30. Name and address of person who Paul Armstrong M					Suite	102, Laure	a 1 MD	20707	
	∜ Sta	te	31. Date filed (Month, Day, Year)	32. Fjeg	istrar's Signa		1		102, Laure	עוצו פיב-	20/0/	
	Registra	ar.	JAN 23 2	004	was	Ø	sporks					

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of F tificate of	lealth and N Death	Mental Hyg	iene 20		03972	
	Dharisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death	
	Physici /Medic		Carl	Walto	n	Jr.		January			6:15 a M	
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County o			
			4209 Bar Harbor F  5. Social Security Number 6. Sep		last hirthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montg			
	Funeral Director		S. Godiai Godani, italia	§M 2□F 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec. 15	, 1928	Ind	lece (State or Foreign try) iana	
1	D		Usual Residence of Decedent									
	nylan how	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	0d. Inside City Limits 1 ☐ Yes 2 ②No	
	Ba-f	cto	Maryland Montgon	nery	Olney			1 -				
	or 2	Director	10e. Street and Number			10f. Zip Code	0	1	0g. Citizen of W		try?	
	s 23s	erai	4209 Bar Harbor P	lace 12. Was Decedent Ever in U	S 13 V	2083	Z Ilspanic Origin? (Sp	pecify Yes or No.	US 14 Bace		an Indian,	
(0	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28a-f ehow the Medical Examinat must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 ☐ Noj Q /, 5	I	Yes, specify Cubi	an, Mexican, Puerto	Rican, etc.)	Black	, White, e	etc.	
Maryland 21215-0036	ral', o	by	3 Widowed 4 Divorced	If Yes, Give 1945 Year or Dates: 1955		☐ Yes 2⊠ No	Specify:		Specify:	Whit	.e	
5	72 h natu	Completed	15. Decedent's Edu (Specify only highest grade		(Give	ent's Usual Occup kind of work done	during most of worl	king	16b. Kind of Bus	iness/Ind	lustry	
12	within ane. Ihen	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		OONOTuse retired urant Ma			Food an	ıd Be	verage	
N D	filed y Hygie ther t		17. Father's Name (First, Middle, Last)		neoca	or and m	18. Mother's Nam	ne (First, Middle,			Verage	
an	d be ental	To Be	Carl Walton Si	•			Arze11:	a Mae Bo	nts			
چ	shoul nd Me mark	Ě	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street	and Number or Ru			tate, Zip	Code)	
S	nd 2 alth a 27 is		Deborah Walton/Da	aughter	4209	Bar Harb	or Place	Olney,	MD 2083	2		
Je,	of Height item		20a. Method of Disposition	1 /	Place of Disposemetery, crem	sition (Name of natory or other place	ce) Tanu	Date ary 19	20c. Location - C	City or To	wn, State	
E	Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	G G		Heaven			Silver S	Sprin	ng, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or items 23a or 28a-f ehow enty injury 22.		21. Signature of Funeral Service License	99	Fr	Name and Addre	ssof Facility Collins sity Blvd	Funeral	Home In	c. ring	, MD 20901	
1	100		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately Blvd. W., Silver Spring, MD.  Approximately Blvd. W., Silver Spring, MD.  Approximately Blvd. W., Silver Spring, MD.									
	Physician		Immediate Cause (Final disease or condition	Colon Cance						į.	Onset and Death  1 year	
100	/Medical		resulting in death)	Due to (or as a conseq	uence of):							
Н	Examiner	_		)						_		
	pe gi	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or):							
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
8760,	cate be executed physician and the burial-transit	dical E		4								
.89	ificati g phy as the	edic										
ŏ	h cert endin	N/M	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date			
.O. Box	that the death certified by the attending of detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d 9 Unknown		Other (specify)	·		Mont	n	Day Year	
<u>a.</u>	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditions con	atributing to death but not rec	ulting in the ur	iderlying cause an	on in Part I	23e Did to	nacco use contrib	hute to th	e cause of death?	
ds,	og gr	d by	Fait ii. Other significant conditions con	ambuting to doubt but not res	aiting in the ti	iddinyning daasa giv	on as a cir.	T			abiy 4 □Unknown	
Ö	w requir been si should	Completed				-		24a. Was a	n 24h W	ere autor	psy findings available	
Re	he fav e has ige 2	dmo						autops perfori	ned? pr	ior to come	npletion of cause of	
ta		0	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes : th (Check only on		Yes	2 No	
>	Physician: this certific ral director,	To B	eyaminer?	lospital: 1   Inpatient 2	ER/Outpatien	3 DOA Oth	or	ome 5 🔀 Reside		(Specify	·)	
0	g Phys ter this neral di	L:u	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe ho	w injury occurre	d		
0	Attending or death.	atlc	1 XNatural 5 Pending 2 Accident investigation				Yes 2 □ No					
Division of Vital Records,	or Atta	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, lactory, office		28f. Location (Si City or Town	reet and Number n, State)	r or Rural	Route Number,	
	pital ours a neral [		29a. Certifier 1 A Certifying Physical Certification Physical Physical Certification Physical Certification Physical Certificat	sician: To the best of my kno	wledge death	occurred at the fir	ne date and place	and due to the c	ause(s) and man	ner as st	ated	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		ner: On the basis of examina and manner stated.								
	To the within 2 To the complet	ĕ	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	(Month, E	Day, Year)	
7_	1+0		Kuller	10 -		D458	380		January	16,	2004	
(-	1		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, I	Print)						
	ソ		Leon C. Hwang M. 31. Date liled (Month, Day, Year)	D. 1396 Pi			ckville,	MD 2085	0			
	Sta Registr		JAN 2 0 20		B	Spark	2					

Kenneth C. Williams Sr. 04-0516 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep State of Maryland / Dep Registrer Ce	eartment of Health and Mertificate of Death	ental Hygie	
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
п	Physicia		Kenneth C. Williams	, Sr.		18, 2004 5:35 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			2104 County Road Apt. 101	District Heigh		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye	9. Birthplace (State or Foreign Country) No. Carolina
	Director	}	238-82-7280 X STATE STAT		Mar. 5,	1930 NO.Calolina
	/land		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mar.	į	Md. Prince Georges C1	inton		1 G Yes 2 □ No
	or 28.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	hours after death with the Maryland turel; or Iteme 23e or 28e-f show al Examiner must be notified at		8604 Woodyard Road	20735		USA
	er dez	Funeral	Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No It Yes, Give X Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
aryland 21215-0036	2 hou	ed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	166	o, Kind of Business/Industry
215	within 72 ene. than "nat	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)		
2	od wit	Con	12	Laborer		ounty Government
2	be filed ital Hygid of other avant, II	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name Ann Ba	(First, Middle, Maid	den Sumame)
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or Itama 23e or 28a-f ahow aumatic avant, the Medical Examiner must be collised.	2	George T. Williams	ling Address (Street and Number or Rura		ity or Tourn State Zin Code)
Mai	s 1 and 2 should f Health and Men item 27 is merks other traumatic		(3011) 80	1 Ashley Lane		30087
Ġ,	1 and 2 Health Iam 27 i		20a Method of Disposition 20b. Place of Disp	position (Name of	eorgia Pate 20c	Location - City or Town, State
timore,	Pages net of int; if it		1 VRurial 2 I Cremation 3 I Removal from State	ematory or other place) ahChurchCem 1/2	25/04 Wa	1stonburg, N.C.
alti	그 든 본 수		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		
ä	Departing Department of the population of the po			alph Williams Fu 813 Potomac Ave		
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	no ochota Cerdier	water 1	Onset and Death
	/Medical Examiner		resulting in death)  Du lo (or as a consequence of):			
	Examine	_	Sequentially list conditions, if any leading to immediate			
	bed Isit	nlne	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	al-trai	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	<u>ea</u>				
9	tificat ig phy as th	ledic				
Вох	th cer tendir r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
О.	e dea the at ned fo	sici	in the past 12 months?  1	Other (specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>а</u>	hat the d by setach	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ds,	signed I	Completed by	Fett hus chanic elabolism		1 🗆 Yes	2 No 3 Probably 4 Unknown
S	w requir been si should	ete			24a. Was an	24b. Were autopsy findings available
Rec	he lav e has	m d			autopsy	prior to completion of cause of death?
ā			25. Was case referred to medical	26. Place of Death	(Check only one)	No 1907es 2 No
<u> </u>	S S	To Be	examiner?  Hospital: 1 Inpatient 2 ER/Outpatie	Other	0.000	6 DOther (Specify) At scene
Division of Vital Record	Attanding Physician: ir death. ector: After this certification in the funeral director.	L:uc	27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury Injury	of 28c. Injury at Work?	28d. Describe how i	njury occurred
Sio	andir eath. or: Af	catle	2 Accident investigation	M 1 Yes 2 No		
$\frac{3}{2}$	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, lactory, office	City or Town, S	t and Number or Rural Route Number, tate)
7	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director; After the completely filled in by the funeral	I Ce	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea	ith occurred at the time date and place	and due to the care	e(s) and manner as stated.
	Hospita 24 hours Funeral etely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Dey, Year)
			Theodor U. Vid	O.C.M.E.	Jai	nuary 19, 2004
•	(4)	-	30. Name and address of person who completed caus of death (Item 23a) (Type			
			THEODORE Milling	111 Penn Street,	Baltimore	e, Maryland 21201
Øi	Sta Registi		JAN 2 2 2004 22. Registrar's Signature	At 1		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Day 2004 **Physician** 8:00 PM WALKER 1 MILLICENT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S LANHAM MAGNOLIA CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** 1 M 2 TXF 92 8 16 1911 213-21-5977 Guyana Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hyglene. Important: If Item 27 Is marked other then "natural", or Itams 23a or 28a-f show empty injury or other traumatic event, Itle Mardical Examinar mast be notified at once. 12 Yes 2 □ No Director PRINCE GEORGE'S HYATTSVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20782 U.S.A. 2705 KIRKWOOD PLACE # 101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Typesetter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosaline .Iones Walker George 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4407 Saddle River Drive Bowie, Maryland 20720 Leslie Telford/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Riverdale Crematory 1-19-2004 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Carcinoma of the Rectum /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 √2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 21X No 1 Yes 2X No 1 TYes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA this is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Director: , 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D25071 1-15-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7404 Executive Place # 502 Lanham, Maryland 20706 Don Yablonowitz 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 1 2004 porte Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 14, 2004 John Η. White 1:41p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth

(Month, Day, Year)

June 9, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1<del>∏</del> M 2□ F 226 18 4501 83 Virginia Director Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or Items 23a or 28e-f sho other traumatic event, the Maxical Examinar must be notified at 1√2 Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 314 34th Place, N.E. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) Protective Officier Government Pernii. Pages 1 and 2 should be file V Dep rtment of Health and Mental Hy Importent: If fire Z7 Is marked oth any injury or other traumatic event QDGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin White, Sr. Myrtle (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Mitchell / Niece 4231 Nash St., N.E. Washington, D.C. 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cem. 1/17/2004 Wash., D.C. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode from the cardiac of recording areas. The first only one cause on each line. 2001.7 Troximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septic Shock /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending | | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be c ð End Stage Renal Failure 1 Yes 2 No 3 Probably 4 ™Unknown Completed Infected Left Foot, HTW 24b. Were autopsy findings available prior to completion of cause of death? autopsy ¥D No certificate Diabetes Mellitus 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 X No this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 01/15/2004 29c. License number 29b. Signature and title of certified D45471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Adventsit Hospital Negussie

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month Pay, Year) 2004

32 Registrar's Signature

	1	1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	004 03976
Physician /Medical Examiner	4	WOODSIDE NURSING Center Silver Spring Ho	3. Time of Death 2004 5:00 pM  nty of Death  ONE FU
Funeral Director	0	Joan Sacial Security North Day Hours Min. J. Month, Day, Year)  J. A. 30-6612 1 M. 2 F 78 Yrs. Months Days Hours Min. J. Month, Day, Year)  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	9. Birthplace, (State or Foreign Country)  10d. Inside City Limits  10d.Yes 2 □ No
buter death with the Maryland rice tens 23e or 28e-f show ricer must be notified at Funeral Director	-	10e. Street and Number  10e. Street and Number  10f. Zip Code  2018  10g. Citizen of Longton	of What Country?
<u>a</u> ≗ ₫ .5		3 Widowed 4 Divorced Vear or Dates:	Race - American Indian, Black, White, etc.  Werkcan  Business/Industry
Ind 21215-00 be filed within 72 hou tall Hygiene. de other than "nature of overt, the Medical E. Be Completed			NEVNMENT RD
aryla s should and Men s marke sumatic		19a_Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Rural Royte Number, City of Tox	
timore,  t. Pages 1 and rithent of Heal remains: If item significant of the significant or other rither significant or other significant or other significant sign		Constitution (Marco)	
Bal permi Depart Impo Impo		23a. Partí. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	(Y ) == (m)
bhysician ate be executed whistian and the burial-transit the burial-transit the burial-transit than t		d	far yrs
S, P.O. Box 68760, es that the death certificate be e. gined by the attending physician be detached for use as the buriable Physician/Medical E.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Date of delivery Month Day Year
cords, P. w requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use of the underlying cause given in Part I.	
Vital Record steien: The law requir rectificate has been si irector, page 2 should		24a. Was an autopsy performed?  1 Yes 2 No 25. Was case referred to medical examiner?	b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
n of ng Phy after this uneral d	2	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 Residence 6 C	
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t. Medical Certificati	200	4 Homicide building, efc. (Specify)  29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	manner as stated. ce, and due to the cause(s)
To the Hospi within 24 hou To the Funei completely fill	5	Anevalevelle no D38262 Jane	oned (Month Day Year)
State Registrar		DRAMENDITRATTA 240/Research BLVD Suite 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature	30 MD 20850

			1- For State Registrar	State of Maryland	l / Depa		lealth and M	Mental Hy	_	
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Cuturine W	ood				2. Date of Dea	Day Ye	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, give s  VINCE ( LOVEL)  5. Social Security Number 6: Sex	A Hosp Cent		AL	LV Li  If Under 24 Hrs. Hours Min.	8. Date of Birt	4c. County of I	Death  Birthplace (State or Foreign Country)
	Director	5	Usual Residence of Decedent  10a. State  10b. County	10c. City,	Yrs. Town or Lo			July 6	, 1916 M	laryland 10d. Inside City Limits
	h with the M 23a or 28a-f	ai Directo	MD Prince Geo  10e. Street and Number  7205 Cross Street	orge l	rorest	101. Zip Code 20747			10g. Citizen of Wha	1 No 1 No 1 Country?
036	within 72 hours after death with the Maryland ene. than "natural", or Heme 23a or 28a-f show ha Medical Evaminet must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify: P	Americen Indian, Vhite, etc.
Maryland 21215-0036	d within 72 ho giene. er than "natur roa Medical	completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done OO NOT use retired Maker	ation during most of work t)	king	16b. Kind of Busine	,
yland	nould be file if Mental Hy narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Andrew Matthews				Linnie	e Chase	Maiden Sumame)	
	s 1 and 2 sh Health and Ifem 27 is n other traun		19a. Informant's Name/Relationship (Typ. Shirley Wood/Daugh) 20a. Method of Disposition	nter 20b. Pla	7205	Cross S	t, Forest		or, City or Town, State MD 20747  20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Ligence	Cec	lar Hi	. Name and Addres	1/19 ss of Facility St	ricklan	Suitland	, MD Services
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or hearf failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Do not ente	er the mode of dyin				Approximate Interval Between Onset and Death
8760,	ate be executed typicien and the burial-transit	lical Examiner	Sequentially list conditions, any leading Laminad as cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecue		-				
.O. Box 68	Attending Physician: The law requires that the death certifica r death. sctor: Atler this certificate has been signed by the attending phy the funeral director. page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ords, P	w requires that been signed b should be deta	ed by Pł	Part II. Other significant conditions con Stage N		ing in the un		en in Part I.	23e. Did to		e to the cause of death?
al Records,	nicien: The law recertificate has be rector, page 2 sh	Completed	Severe per	sphercel v	ousc	ulcv	Diseers	24a. Was a autops perform	sv prior	
<b>\rightarrow</b>	yeicien: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Mnpatient 2 ☐ EF	R/Outpatient	Othe	26. Place of Deatl			-
Division of Vital	anding Phyeath. or: After this ne funeral di	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury	28c. Injury Work	at		ence 6 Other (Sow injury occurred	ipecify)
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town	n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	edical	29a. Certifier (Check only one)  2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim estigation, in my op	e, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	2		29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)
0	(3)		30. Name and address of person who con	mpleted cause of death (Item 2	(Type, F	D-C	55220	)	4141	04
1			3001 Hospital  31. Date filed (Month, Day, Year)	Registrar's Signatur	Che	very	Km 7	0785		
	Sta Registr		JAN 2 0 2004	Blance #	loss	les "				

	-	= State Registrar		<i>Ce</i> .	rtificate of L	Jean		Reg. N	lo.	` .	00011
		1. Decedent's Name (First, Middle, La	st)				2. Date of Month		ay Ye	1	3. Time of Death
/sicia		SHIRLEY BOLI	DEN WHITEMA	N			Janu		5, 200		1:16 P
ledic: amine		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of D	eath	4	c. County of D	eath	
		Holy Cross Hospi	ital		Silver	Spring	ζ		Montgo		
eral		5. Social Security Number 6. S	Sex 7. Age (In yrs	s. last birthday)	·	If Under 24		Birth Day, Yea	ar) 9.	Birthplac	ce (State or Foreig
ctor		038-09-2388	1□M 2½F 94	Yrs.	WOTHIS Days	, ,	Oct.	12,	1909 P		ídence, I
	ļ	Usual Residence of Decedent								1.0-	. I - id- Ob- Limit
3		10a. State 10b. County	10c. C	City, Town or Lo	ocation					100	I. Inside City Limit 1X Yes 2 ☐ N
N N	Director	Maryland Prince G	eorge's Fo	ort Was	hington						120162 2 114
9	Ĭ	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What	t Country	y?
aumatic event, the Medical Examinar must be notified at		2311 Rosecroft E	31vd.		2074	4			U.S.A.		
9	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin	(Specify Yes o	No-	14. Race - A Black, V		
	F	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		,	Specify:		_
	þ	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		12 (03 2 <u>4</u> 2 (10	opoony.			эреспу.	Бтас	κ
	Completed	15. Decedent's E (Specify only highest gro	ducation	16a. Dece	dent's Usual Occupa	ation during most of	working	16b.	Kind of Busine	ess/Indu	stry
	현	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		Fo	deral	Corro	rnment
	0	12th			Computer A					GUVE	Timent
	Be	17. Father's Name (First, Middle, Last	_				Name (First, Mic				
	ToE	Dennis K. Bold	len			Carri	e T. Ti	1ghma	ın		
		19a. Informant's Name/Relationship (	(Type, Print)	19b. Maili	ing Address (Street	and Number o	r Rural Route No	ımber, City	y or Town, Sta	te, Zip C	code)
		Ernest W. Huggs,	, Jr./Son	2311	Rosecroft	t Blvd.	, Fort	Washi	ngton,	MD	20744
		20a. Method of Disposition		Place of Dispo	osition (Name of	(a)	Date	20c.	Location - City	y or Tow	n, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ※ Other (Speci	Removal from State  Entombmented	ort Lin	matory or other place Mausol	eum   fer√ 1	/22/2004	Bre	entwood	l. Ma	arvland
		21. Signature of Funeral Service Lice									- J
any injury or outer once.		A	T	F	2. Name and Addres	LN FUN	ERAL HOM	E	M	1	and 207
-		1 1 many 11. 1									
		23a Part 1 Enter the disease or com	nolications that caused the de	ath. Do not en	401 Blades	nsburg Ig. such as cal	Koad B	rentw rv arrest.	700 <b>a</b> , M	F	Approximate
70. 10.0		23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the devone cause on each line.	ath. Do not en	401 Blades ter the mode of dyin	nsburg ig, such as cai	Koad • B	rentw ry arrest,	700 <b>a</b> , M	li li	
		Immediate Cause (Final disease or condition		ath. Do not en	ter the mode of dyin	nsburg g, such as cai	Koad, B diac or respirato	rentw ry arrest,	700 <b>d</b> , M	li li	Approximate nterval Between
al		Immediate Cause (Final	nplications that caused the de rone cause on each line.  a. <u>Respirator</u> Due to (or as a consc	ath. Do not en	ter the mode of dyin	nsburg g, such as car	KOAD, B	rentw ry arrest,	700d, M	li li	Approximate nterval Between
al		Immediate Cause (Final disease or condition resulting in death)	a. Respirator Due to (or as a conso	ath. Do not encry Arres	ter the mode of dyin	nsburg g, such as cai	ROAD, B	rentw	700 <b>d</b> , M	li li	Approximate nterval Between
al ier	ner	Immediate Cause (Final disease or condition resulting in death)	a. <u>Respirator</u> Due to (or as a consc	ath. Do not encry Arres	ter the mode of dyin	nsburg	KOAD, B	rentw	700d, M	li li	Approximate nterval Between
al er	aminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. It any, leading to him what cause. Enter Underlying Cause (Disease or injury that initiated events	a. Respirator Due to (or as a conso	exth. Do not en	ter the mode of dyin	nsburg Ig, such as cai	KOAD, B	rentw	700d, M	li li	Approximate nterval Between
eal ier	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Respirator Due to (or as a conso	exth. Do not en	ter the mode of dyin	nsburg g, such as cau	KOAd, B	rentw	700d, M	li li	Approximate nterval Between
cal ner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. It any, leading to him what cause. Enter Underlying Cause (Disease or injury that initiated events	a. Respirator Due to (or as a conso	exth. Do not en	ter the mode of dyin	nsburg g, such as car	KOAD, B	rentw ry arrest,	700d, M	li li	Approximate nterval Between
eal ner	dical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to any cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Respirator Due to (or as a conso	exth. Do not en	ter the mode of dyin	nsburg g, such as ca	KOAd, B	rentw ry arrest,	700d, M	li li	Approximate nterval Between
al er	dical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const d.  23c. If yes, outcome of preg	y Arres equence of):	ster the mode of dyin	g, such as car	Koad, B	rentw ry arrest,	23d. Date of	f delivery	Approximate niterval Between Onset and Death
al er	dical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to any area cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Respirator Due to (or as a consection of the total and the consection of the cons	y Arresequence of): equence of): equence of):	ter the mode of dyin	g, such as car	Koad, B	rentw ry arrest,		f delivery	Approximate nterval Between Onset and Death
ner seine se	dical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d.  23c. If yes, outcome of preg	y Arresequence of): equence of): equence of):	st.	g, such as car	Koad, B	rentw ry arrest,	23d. Date of	f delivery	Approximate nterval Between Onset and Death
er er	dical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Pregnant at time or 9 Unknown	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):	Ectopic pregnancy  ○ Other (specify)	g, such as car	diac or respirato	ry arrest,	23d. Date of Month	f delivery	Approximate nterval Between Onset and Death
cal ner	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to any area cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Pregnant at time or 9 Unknown	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):	Ectopic pregnancy  ○ Other (specify)	g, such as car	diac or respirato	ry arrest,	23d. Date of Month o use contribu	f delivery	Approximate nterval Between Onset and Death  Approximate and Death
eal	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to any area cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Pregnant at time or 9 Unknown	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):	Ectopic pregnancy  ○ Other (specify)	g, such as car	23e. I	ny arrest,	23d. Date of Month  o use contribu  2 \( \text{No} \) 3 \( \text{Carter} \)	f delivery	Approximate nterval Between Onset and Death  A year cause of death?  Course of death?  Course of death?
cal	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to any area cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Pregnant at time or 9 Unknown	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):	Ectopic pregnancy  ○ Other (specify)	g, such as car	23e. l	Did tobacci ☐ Yes  Was an uutopsy	23d. Date of Month  o use contribu 2 \( \text{No} \) 3 \( \text{Square} \)	f delivery	Approximate niterval Between Driset and Death Park
cal per	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, is adong to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  Part II. Other significent conditions	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Pregnant at time or 9 Unknown	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):	Ectopic pregnancy  ○ Other (specify)	rg, such as car	23e. I	Did tobacc  ☐ Yes  Was an tulopsy seriormed; es 2 ☑ 1 ☐ 1	23d. Date of Month  o use contribu 2 \( \text{No} \) 3 \( \text{Square} \)	f delivery	Approximate niterval Between Driset and Death Park
cal per	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to any area cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown contributing to death but not re	y Arresequence of): equence of)	□Ectopic pregnancy □ Other (specify) underlying cause giv	en in Part I.	23e. I	Did tobacco	23d. Date of Month  o use contribu 2 \( \text{No} \) 3 \( \text{Solution} \)  24b. Wer prior deat  \( \text{No} \) 1 \( \text{D} \)	f delivery	Approximate niterval Between Driset and Death Park
cal ner	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significent conditions  25. Was case referred to medical examiner? 1  Yes 2 No	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Te 4 Pregnant at time of 9 Unknown  Contributing to death but not re	Arres equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):  equ	□Ectopic pregnancy □ Other (specify)  underlying cause giv	en in Part I.  26. Place of	23e. I 24a. 1 1 Y Death Check o	Did tobacco	23d. Date of Month  o use contribu 2 \( \text{No} \) 3 \( \text{Solution} \) 24b. Wer prior deat No 1 \( \text{1} \)	f delivery	Approximate niterval Between Onset and Death  A year cause of death?  Doly 4 Unknown or year of the poly and
er	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significent conditions	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown contributing to death but not re	ath. Do not en	□ Ectopic pregnancy □ Other (specify) □ underlying cause giv	en in Part I.  26. Place of ler:  4 \( \sum \text{Nursion} \)  4 \( \sum \text{Nursion} \)	23e. I 24a. 1 1 Y Death Check o	Did tobacco	23d. Date of Month  o use contribu 2 \( \text{No} \) 3 \( \text{Solution} \)  24b. Wer prior deat  \( \text{No} \) 1 \( \text{D} \)	f delivery	Approximate niterval Between Onset and Death  A year cause of death?  Doly 4 Unknown or year of the poly and
er	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annuance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator Due to (or as a consection)  B. Pneumonia Due to (or as a consection)  C. Due to (or as a consection)  d	Particle and the second of the	□Ectopic pregnancy □ Other (specify) □ underlying cause give	en in Part I.  26. Place of er: 4 \( \text{Nursi} \) Nursi	23e. I  24a. 1  1 V  Death Check of the congression	Did tobacce  Yes  Vas an ulopsy  variety  one  2 ☑ 1	23d. Date of Month  o use contribu 2 No 3 24b. Wer prior deat of the contribution of t	f delivery  Detection to the probability of the complete to the probability of the complete the probability of the complete the probability of the	Approximate nterval Between Onset and Death Pearl Pear
eal er	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annual accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator Due to (or as a const b. Pneumonia Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 4 Pregnant at time of 9 Unknown  Contributing to death but not re  Hospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year)	pancy stal death 5 (esulting in the control of the	□Ectopic pregnancy □ Other (specify) □ underlying cause give	en in Part I.  26. Place of ler:  4 \( \sum \text{Nursion} \)  4 \( \sum \text{Nursion} \)	23e. I 24a. Y Death Check of 28d. Desc.	Did tobacce  Yes  Vas an ulopsy  variety  one  2 ☑ 1	23d. Date of Month  o use contributed in the contri	f delivery  Detection to the probability of the complete to the probability of the complete the probability of the complete the probability of the	Approximate niterval Between Diset and Death Personal Per
מוום וחופוש מוופכיתו לאמפ ל פונסמים הם הפומפים כי הפס בי ונים הפיום וחופוש מוופכיתו לאמפ ל פונסמים הם הפומפים כי הפי בי ונים הפיום וחופים וחופים וחופים הפיום בי הפיו	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to annual cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator  Due to (or as a const b. Pneumonia  Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown  contributing to death but not r  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	pancy stal death 5 (esulting in the control of the	□Ectopic pregnancy □ Other (specify) □ underlying cause give	en in Part I.  26. Place of ler:  4 \( \sum \text{Nursion} \)  4 \( \sum \text{Nursion} \)	23e. I 24a. Y Death Check of 28d. Desc.	Did tobacco  ☐ Yes  Was an  was an  was an  was an  an  on (Street	23d. Date of Month  o use contributed in the contri	f delivery  Detection to the probability of the complete to the probability of the complete the probability of the complete the probability of the	Approximate niterval Between Diset and Death Personal Per
The fundral director, page 2 should be detached for use as life bullar-trains.	Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator Due to (or as a consection)  b. Pneumonia Due to (or as a consection)  c. Due to (or as a consection)  d. 23c. If yes, outcome of pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant at time of a polyment of the pregnant of the pr	path. Do not en  y Arres equence of):  equen	□Ectopic pregnancy □ Other (specify) □ underlying cause give	en in Part I.  26. Place of the state of the	23e. I 24a. \( \frac{1}{2} \) 24a. \( \frac{1}{2} \) 28d. Describe 28d. Describe 28f. Location City of the control of the cont	Did tobacco Yes Was an ulopsy performed less 2 1 1 0 ne Residence libe how in the cause	23d. Date of Month  o use contribut 2 No 3 [ 24b. Were prior deat 1 ]  6 Other (and Number cate)  and Number cate)	f delivery  D  te to the Probat  e autops r to comp th? Yes 2	Approximate niterval Between Dnset and Death Dea
The funding director, page 2 should be detached for use as the bundaring in	Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator  Due to (or as a const b. Pneumonia  Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown  contributing to death but not r  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - Al building, etc. (Spe	path. Do not en  y Arres equence of):  equen	□Ectopic pregnancy □ Other (specify) □ underlying cause give	en in Part I.  26. Place of the state of the	23e. I 24a. \( \frac{1}{2} \) 24a. \( \frac{1}{2} \) 28d. Describe 28d. Describe 28f. Location City of the control of the cont	Did tobacco Yes Was an ulopsy performed less 2 1 1 0 ne Residence libe how in the cause	23d. Date of Month  o use contribut 2 No 3 [ 24b. Were prior deat 1 ]  6 Other (and Number cate)  and Number cate)	f delivery  D  te to the Probat  e autops r to comp th? Yes 2	Approximate niterval Between Dnset and Death Dea
במן ביים ביים מוספות להמליב אונים מים מפומרופת וכן מפס מא ווים ביים מוספות להמליב אונים ביים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים ביים ביים מוספות להמליב אונים ביים מוספות להמליב אונים ביים ביים ביים ביים ביים ביים ביים ב	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to annuance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator Due to (or as a consist.)  Pneumonia Due to (or as a consist.)  C. Due to (or as a consist.)  Due to (or as a consist.)  d	path. Do not en  y Arres equence of):  equen	□Ectopic pregnancy □ Other (specify) □ underlying cause give	en in Part I.  26. Place of ler: 4 \( \text{Nursing At Yes} \( 2 \) \( \text{No ne, date and ppinion, death} \)	23e. I 24a. \( \frac{1}{2} \) 24a. \( \frac{1}{2} \) 28d. Describe 28d. Describe 28f. Location City of the control of the cont	or arrest,  Did tobacco  Yes  Was an uniopsy performed residence ribe how in the cause me, date a residence residen	23d. Date of Month  o use contribut 2 No 3 [ 24b. Were prior deat 1 ]  6 Other (and Number cate)  and Number cate)	f delivery D  f delivery D  f to the autops of to complete to complete to the autops of the autops o	Approximate retrieval Between Onset and Death De
the funeral director, page 2 should be detached for use as the burtan-transit	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annuance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator Due to (or as a consist.)  Pneumonia Due to (or as a consist.)  C. Due to (or as a consist.)  Due to (or as a consist.)  d	path. Do not en  y Arres equence of):  equen	Ectopic pregnancy Other (specify)  underlying cause give  and 3 DOA of 28c. Injury Wor M 1 Coursed, factory, office	en in Part I.  26. Place of the thick of the	23e. I 24a. \( \frac{1}{2} \) 24a. \( \frac{1}{2} \) 28d. Describe 28d. Describe 28f. Location City of the control of the cont	Did tobacco  Yes  Was an ulopsy performed less 2 1 1 1 one Residence libe how in the cause me, date a 29d. I	23d. Date of Month  o use contribu 2 No 3  24b. Wern prior deat No 1  6 Other ( njury occurred  and Number of ate)	f delivery  D  te to the Probat  e autops r to comp th? Yes 2  Specify)  or Rural if	Approximate interval Between Dinset and Death De
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property of the	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to annuance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Respirator  Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)  C. Due to (or as a consection)  Due to (or as a consection)	pancy stal death 5 (security)  ER/Outpaties 28b. Time of Injury stal death and a control of the	□Ectopic pregnancy □ Other (specify) □ Other (specify) □ underlying cause giv  ont 3□ DOA Oth of 28c. Injury M 1□ treet, factory, office th occurred at the tir nvestigation, in my of 29c. Licens D-52	en in Part I.  26. Place of the thick of the	23e. I 24a. \( \frac{1}{2} \) 24a. \( \frac{1}{2} \) 28d. Describe 28d. Describe 28f. Location City of the control of the cont	Did tobacco  Yes  Was an ulopsy performed less 2 1 1 1 one Residence libe how in the cause me, date a 29d. I	23d. Date of Month  o use contribut 2 No 3 [ 24b. Were prior deat 1 ]  6 Other (Anity occurred and Number cate)  and Number cate)  (s) and manner and place, and Date signed (Anity occurred (	f delivery  D  te to the Probat  e autops r to comp th? Yes 2  Specify)  or Rural if	Approximate niterval Between Dnset and Death Dnset and Death Dnset and Death Dnset and Death Dnset and Death Dnset and Death Dnset and Death Dnset and Dnset

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MARLENE WINN January 11, 2004 23:23 P 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Wash., D.C. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2)(2) F 577-52-4702 65 Yrs. June 6,1938 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits X□Yes 2□No Oxon Hill |Maryland |Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 4904 Glassmanor Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notifyes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 TMarried 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Yes 2√ No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4 or 5+) 12thComputer Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vernell Minor Clarence Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Glassmanor Dr. Oxon Hill, Md. 20745 Nathaniel Winn/husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Washington Nat 1 Cem. 1/17/04 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Frazier's Funeral Home, Inc. 389 R.T. Ave., N.W. Wash., I

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wash.,DC 20001 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 17 cemin Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9☐ Unknown 9 Unknown Part II. Ofther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Im/c 310

29c. License numbe

10055120

29d. Date signed (Month, Dey, Year)

Washing for DC 20032

12 2004

the attending physicien a ched for use as the burial-Box P.0. Records, certificate has Vital this ō After Division death. Director: hours after within 24 hours a

NINN

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 le marked other then "naturel", or Iteme 23a or 28a-1 ehov treumatic event, the Medical Exercitor must be notified at

permit. Pages 1 and 2 is Department of Health ar Important: If item 27 to eny injury or other treu QDCs.

**Physician** 

/Medical

Examiner

Maryland 21215-0036

Baltimore,

Funerai Director

Completed by

Be

2

Examine

by Physician/Medical

Completed

2

Certification:

29a. Certifier

29b. Signature and title of certifier

Kichard Kalmer

page 2

funeral director,

completely filled in by the

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 2 2 2004

anne (m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328 Southern Are in ) . Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11:18A M Therese Yarborough January 18, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital Clinton Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Ye 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☑ F 231-56-2100 74 Director May 22, Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show ar inval be notified at Maryland Prince George Capitol Heights ty Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1107 Mentor Avenue 20743 United States Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 21 No 1 ☐ Never Married 2 X Married r than "natural", or i Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No à If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) Homemaker Private nt of Health and Mental Hygie If item 27 is marked other or other treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be Elisa Weinz Martin Muller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Carl Yarborough/Spouse 1107 Mentor Avenue, Capitol Heights, MD. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Department of P Important: If its any injury or of once. 1 

Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Jan. 23, 2004 Cheltenhem, MD. 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. permit 21. Signature of Funeral Service Licenses 20747 23a. Pert1. Enter the diseas e, or complications that caus List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physicien as the burial-t Box 68760 Physician/Medical the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ as been si 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed page certificate Division of Vital 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and litle dicertify 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1012 Walderf, red. Warnington Old 326 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 1 2004 Registrar

DHMH 17 Rev 1/2001

Varbornh

			- FOI	epartment of Health and M Certificate of Death		ene 2004	0.201	
			Decedent's Name (First, Middle, Last)		2, Date of Death Month	Day Year	3. Time of Death	
	Physici: /Medic		Jack Young		Jan.	18 2004	6:15 P M	
7	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth		
			Charlotte Hall Retirement Home  5. Social Security Number   6. Sex   7. Age (In yrs. last birtle)	Charlotte Hall	8 Date of Birth	St. Mar	DIACE (State or Foreign	
4F	Funeral Director		100	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	th, Day, Year)  11,1915  Texas		
		ŀ	Usual Residence of Decedent		OCC. 11,			
	within 72 hours after death with the Maryland sne. than "natural", or iteme 23e or 28e-f ehow he Medical Examinar must be notified at	<u>.</u>	10a. State   10b. County   10c. City, Town   Maryland   St. Marys   Charlo	or Location tte Hall		1	10d. Inside City Limits 11€ Yes 2 □ No	
	Ba-f o	octo			100	g. Citizen of What Cour		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or iteme 23e or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at 2008.	by Funeral Director	10e. Street and Number 29449 Charlotte Hall Road	10f. Zip Code 20622	100	U.S.A.	nu y r	
	ne 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	crly Yes or No-	14. Race - Americ		
9	after o	F	Amed Forces?		Hican, etc.)	Black, White,		
93	ours ours	d by	3 Widowed 4 Divorced If Yes, Give 1941–46	Λ		Specify: Whi		
5-(	n 72 h	iete	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workit life. DO NOT use retired)	ng 16	6b. Kind of Business/In	dustry	
21215-0036	withir ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ieutenent Colonel		U.S. Arm	ΟV	
	filled Hygin other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma			
lan	ould be d Mental narked o	To B	Henry D. Young	Grace Mu	rrell			
Maryland	2 should be filed withir and Mental Hygiene.  le marked other than aumatic event, than M.			Mailing Address (Street and Number or Rura				
	and and and and and and and and and and			+04 American Dr.,Vill		Lago Vista,		
ore	ges 1 t of H if Ite		1 XBurial 2 Cremation 3 Removal from State	r, crematory or other place)		,		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny injury or other tr 20028.		4 □ Donation 5 □ Other (Specify) ATIIN  21. Signature of Funeral Service Libensee	gton National Jan.	30, 2004	Arlingto	n,Va.	
Bal	Depariment Department of the partment of the p		21. Signature of Funeral Service Licensee	22. Name and Address of Facility MUr 4510 Wilson Blvd., A	phy Fune rlington	eral Homes, 1,Va. 22203	Inc.	
100	Physician /Medical Examiner		23a. Pert1. Enter the disease, of complications that caused the death. Do n shock, or heart lailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the control of	AL INFARCTION		st,	Approximate Interval Between Onset and Death	
,0,	ecuted and -transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen					
8760,		dicai	d					
.O. Box 68	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year	
0	uires that the de signed by the a Id be detached f	by	Part II. Dther significant conditions contributing to death but not resulting in ATRIAL FUBRICLATION, HYPER	the underlying cause given in Part I.		cco use contribute to t	he cause of death?	
0.0	v requires been sign should be	eted				_	ppsy findings available	
Rec	e lav	Completed	CERETHONASCULAR ACCIDENT, P		autopsy	prior to co	mpletion of cause of	
ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical	26. Place of Death				
) \ \ \	Physician: this certific ral director,	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out			ce 6 Other (Specia	<i>(y)</i>	
n C	9 9	ion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Ir	ime of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	vinjury occurred		
Division of Vital Records,	or Attendent fter deat Sirector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fail building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,	
	pita ours era	ledical Ce	29a. Certifier (Check only one)  1	death occurred at the time, date and place, a for investigation, in my opinion, death occurred.	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due t	stated. the cause(s)	
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)	
	- S + O		i Julk Philleton	D 50 76 3	•	01/19/0	9	
)	(5)		30. Name and address of person who completed cause of death (Item 23a) (	29c. License number  D 50 76 3  Type, Print)  CHUH, CHARLO TTE	UMI	MI	-/	
	St	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	AUVILLE CONFEELIE	in un,			
	7 Regist		JAN 2 2 2004 Kenter & A	carles				

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State
Registrar Amend Item#26perVFRBALG8282/11/04EW Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) January 30, 2004 **Physician** 8:05 P M Isadore ABRAMS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 5, 1917 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1□**y**M 2□ F Philadelphia, 186-05-7104 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28e-1 show ury or other traumatic event, the Medical Examinat must be notified at 10a State 10b. County 1 X Yes 2 No Director Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14431 Traville Garden 20850 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 🔀 Married 21215-0036 1 ☐ Yes 2 ➡ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Scrap Metal Dealer Metals 12 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Max Abrams Fannie Prince 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Abrams 14431 Traville Garden. Rockville. MD 20850 spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any injury or Mt. Sharon Cemetery Feb.1, 2004 Philadelphia. PA 21. Signature of Funeral Servin Licensee, 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc. 254 Carroll E. NW Washington, DC 20012 0 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 05. enknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner infection artheter Unknow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and -transit The law requires that the death certificate be executed physicien and s the burial-tr Due to (or as a consequence of): Box 68760. Physician/Medical attending t as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1X Inpatient 2 ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury To the Hospitel or Attending 5 ☐ Pending 44 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Thomicide within 24 hours a To the Funeral I 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Howe mo 00059871 risting Culie anuala 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mb agai medical center Drive Rockville, MD 20850 ristin Parker Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 1 2004 Registrar

				nent of Health and Mocate of Death	ental Hygie	ne 2004	03983				
>	Physici /Medio Examir	al		. City, Town, or Location of Death	2. Date of Death Month	Day Year 4c. County of Death	3. Time of Death  1056AM				
	Funeral Director		274-14-7872 1 M 2 T F 83 Yrs. Mc		8. Date of Birth (Month, Day, Young)		ace (State or Foreign try) hio				
	the Maryland	Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Anne Arundel   Odenton   10e. Street and Number   11	on Of. Zip Code	100	. Citizen of What Count	od. Inside City Limits 1 ☐ Yes 2√☐ No				
36	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-1 show event, the Medical Exam har must be notified at	Funeral	2150 Colonel Way  11. Marital Status 1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Never Married 2 Married 2 Never Married 2 Neve	2 1 1 1 3  Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto F		USA 14. Race - America Black, White, 6	an Indian,				
Maryland 21215-0036	e filed within 72 hours al Hygiene. other than "natural" vent, the Wedical Ex-	Completed by	(Specify only highest grade completed) (Give kind life. DO N	s Usual Occupation of work done during most of workin IOT use retired) e maker	g	b. Kind of Business/Ind					
aryland		To Be (	17. Father's Name (First, Middle, Last)  William  J. Miesle  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Ac	18. Mother's Name Claire ddress (Street and Number or Rural		Bunschew					
Baltimore, M	1 and Health em 27 ther tr		20a. Method of Disposition 1 ☐ Burial 2文 Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cremator	Colonel Way Od (Name of ry or other place)  matory 2-11-0	ate 200	MD 21113 c. Location - City or Toval altimore,					
Baltil	permit. Pages Department of I Importent: If Its any injury or o		21. Signature of Euneral Service Licensee 22. Nat	me and Address of Facility desty Funeral		Ann, M	dgelyAve D 21401 Approximate				
1,092	Physician and Medical Examiner	ical Examiner	cai	cai	cai	cai	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	(Right)			Interval Between Onset and Death
P.O. Box 68	ne death certifics the attending ph hed for use as t	Completed by Physician/Med		opic pregnancy er (specify)		23d. Date of deliver	y Day Year				
	w requires that the stand of the standard by should be detact	ted by Pr	Part II. Other significant conditions contributing to death but not resulting in the underly my ocardial in farchion	ying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?				
ital Reco	The ate h page	0	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed 1 Yes 20	prior to corr	sy findings available inpletion of cause of				
Division of Vital Records,	Attending Physic death.	Certification: To B	examiner?  1  Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined  4 Homicide  Hospital: 1 Impatient 2 ER/Outpatient 3  28a. Date of Injury (Month, Day Year)  N  28b. Place of Injury - At home, farm, street, for building, etc. (Specify)	Other: 4 Nursing Hom 28c. Injury at Work?  1 Yes 2 No	e 5 Residenc	t and Number or Rural					
۵	To the Hospitel or within 24 hours atter To the Funeral Direction completely filled in k	Medical Cer	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occ only one)  Certifying Physician: To the best of my knowledge, death occ only one one of the basis of examination and/or investigand manner stated.	urred at the time, date and place, argation, in my opinion, death occurre	nd due to the caus	e(s) and manner as sta	ated. the cause(s)				
•	within Comp	M	29b. Signature and title of certifier.  30. Name an dress of person completed cause of death (Item 23a) (Type, Print)	29c. License number A-U4176439	S15180 F		9,2004-				
(F	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	BALTMORSIME	2.12	-01					
	Registr	ar	FEB 1 1 2004 Librar & April								

		1	For State	State of Maryla		artment of F				ene 2 (	0 4	03984
			Registrar  1. Decedent's Name (First, Middle, Last)						ate of Death			3. Time of Death
	Physicia								onth Druary	6 2	Year 004	3:05 P M
	/Medic	al			irrows	4b. City. Town, o	r Location		or darry	4c. Count		
	Examin	er	la. Facility Name (If not institution, give stre			Dunda1		0. 200				
16%			821 North Avondal  5 Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year		24 Hrs. 8 D	Date of Birth		timor	
	Funeral			7. Age (m y	82 Yrs.	Months Days	Hours	Min. M	Month Day, Y	921	Mary	ace (State or Foreign try)
	Director								-/ -/ -		TRILY	rand
1	<b>8</b>		Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	cation					10	Od. Inside City Limits
	arylis sho	ō		imore	Dun	dalk						1 ☐ Yes 2 🖾 No
	Bas-f	ecto		IIIOI C	Dan	10f. Zip Code			100	g. Citizen of	What Coun	try?
3	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number				•			Unite	d C+⊃	tos
	ath v	ral	821 North Avondal		11.6 12.5	212		rigin? (Specify	Yes or No-		ce - Americ	
	r de	Funeral	II. Walkar Status	. Was Decedent Ever in Armed Forces?	10.5.	Was Decedent of I If Yes, specify Cub	an, Mexica	n, Puerto Rica	n, etc.)		ick, White,	
S.	or I		1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 2 <b>%</b> No	Specify.	:		Speci	b: Bla	ck
2-003p	within 72 hours after ene. ene. than "natural", or Ita	d by			16a Dece	dent's Usual Occup	nation		16	5b. Kind of 8	Business/Ind	lustry
'n	nat dica	Completed	15. Decedent's Educa (Specify only highest grade of	com <i>pleted)</i>	(Give	kind of work done DO NOT use retire	durina mos	st of working				
2	Athin Pan 9	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		el Worke			E	Bethle:	hem S	teel
7	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)		500	CI MOLICO		ner's Name (Fir	st, Middle, Mi	aiden Suma	me)	
ב	tal H d otl	Be	Major Burrows					d Gaine				
Maryland 2121	should nd Men marke umatic	ို		Drivet.	10h Maili	ng Address (Stree				City or Town	State Zio	Code)
<u>a</u>	2 sh and ie m		19a. Informant's Name/Relationship (Type									
	1 and Health am 27 thar tr		Everett H. Burrows		b. Place of Dispo	lenard M	raarė.	CON COU	irt Du	Oc. Location	- City or To	71and 21222 wn, State
ore	of H of H if ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	moval from State	cemetery, cre	matory`or other pla						
Ě	Pages nent of ant: If it ury or o		*4 ☐ Donation 5 ☐ Other (Specify)	Ba		h. Crema				aurel		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: If itam 27 is marked other than "natural", or itams 23a or 28a-f show Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.		21. Signature / I Fun and Strivice Lumi ee	let proi	112 2	radley-A 134 Will	shton ow Sp	Matthe ring Ro	ews Fur	neral Indalk	Home, , Mar	Inc. yland 21222
4			23a. Part1. Experthe elsease, or complice shock, or heart failure. List only one	ations that caused the c	leath. Do not en	ter the mode of dy	ing, such a	s cardiac or res	spiratory arres	st,		Approximate Interval Between
			Immediate Cause (Final	Wet	a Rhan A	tic fro	Sta	to Co	ruces		10	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a con		1000	200					
	Examiner			Duo 10 (01 us u 001	35425.100 5.7.							
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	sequence of):			11 -				
VV	te d	Examiner	Cause (Disease or injury									
	be execu ician and burial-tra	Ха	that initiated events c. resulting in death) Last	Due to (or as a cor	sequence of):							
760,		calE	: 100									
687	~ × •		d.									
	The law requires that the death certificate the bas been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23	c. If yes, outcome of pr	egnancy					23d. D	ate of delive	ery
Вох	ath c	ian	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	□Ectopic pregnand □ Other (specify)	су			N	fonth	Day Year
o.	the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown								
σ.	that the de led by the a detached i		Part II. Other significant conditions cont	ributing to death but no	t resulting in the	underlying cause g	iven in Part	t 1.	23e. Did tob	acco use co	ntribute to t	he cause of death?
Ś	ires ti signe	þ	(1) Hepper	ensian					1 🗍 Ye	s 2 No	3 🗆 Prot	ably 4 Unknown
Vital Records,	v requir been si should	Completed	07 - 16	2 XT	^				24a. Was an	246	Wore auto	new findings available
ec	law lasb	ple	( acovan	ed DI	)				autopsy	led2	prior to co death?	psy findings available mpletion of cause of
<u> </u>		lo o							1□ Yes 🤌	No No	1 🗆 Yes	2 □ No
ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	-9-1				ce of Death C	heck onlone	3		Hanne Head
	Physicia this cert al direct	2	1 □ Yes 2 □ No		2 ER/Outpatie	ent 3 DOA		Nursing Home	-			N) Court 1/2
Jot	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Pay Yea	ar) 28b. Time Injury	W	ork?		. Describe ho	w injury occ	urrea	
<u>Ö</u>	ttendir death. ctor: Al / the fu	atic	2 Accident investigation	NA	M		Yes 2		MA			15
Division	or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s pecify)	treet, factory, office	Ð	28f.	City or Town	reet and Nur , State)	nber or Run	al Route Number,
Ö	rs after al Dire	Cer										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledical	(Check only 2 Medical Examin	er: On the basis of exa	y knowledge, dea mination and/or	ath occurred at the investigation, in my	time, date a opinion, de	and place, and eath occurred	due to the ca at the time, da	use(s) and i ate and place	manner as s e, and due t	stated. o the cause(s)
	the hin 2 the the l	Med	one)	and manner stated.		29c Lice	nse numbe	r	29	9d. Date sign	ned (Month,	Day, Year)
	To the within To the comple	~	29b. Signature and title of certifier	Ken	- (M)	7	(-)	51		2/9	7/04	1
			The state of the s		0	10.	21	01	1	4/1	101	
	rh		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	e, Print)	AMD	REII I	Blud	Rad	Di	mD 21236
	IV	1	11 (0/7/77/01/17/) - 1	20 Bosistanta	Signature	1000	11.11	1,000		Free	11-	200
		tate	31. Date filed (Month, Day, Year)	32. Registrar's	Jigitatur <del>u</del> ,	1	,					
15	Regis	uali	■ FER 1 1 71814	1. 20 Arigander	Soul	210 00 Fal						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 03985 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Mildred Elaine February 10:40 A M Barbee 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea. **Funeral**  Birthplece (State or Foreign Country) Days 1 □ M 2 🛛 F 80 Yrs. Director May 11, Maryland 212-20-4821 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Items 23a or 28a-f show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.
snt: if Item 27 is marked other than "natural", or Items 23e or 28e-1 show ury or other treumatic event, I've Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8051 Winding Woods Rd 21061 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 2 Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Furniture Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Merryman Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene A. Barbee Husband 8051 Winding Woods Rd., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Depation 5 ☐ Other (Specify) Bayview Crematory, Inc. 2-9-2004 Baltimore, MD Signature of Funeral Service Lightse 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ARCINOMA Years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undervin. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 X No Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VASCULAD Completed ↑ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 3 No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Wither (Specify) 405 PICE 1 Yes 2 No ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after death Pruneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Attending Doctor Wtymae M7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CVCVRIAE-VID, 8021RI7CVICECOWY,31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

O. Box 68760,
<u>a.</u>
Records
Vital
ō
ivision

			1 - For State Registrar	State of Marylan	d / Dep <i>Ce</i>	artment of H rtificate of L	ealth and N Death	Nental Hygid Reg	\$ 0 0 mg	03986
	Physici		1. Decedent's Name (First, Middle,	Last)		BERMAN	J	2. Date of Death Month	Day Year.	3. Time of Death 6: 25 PM
•	/Medic Examin		4a. Facility Name (If not institution, Sinai Haspital	give street and number)  of Baltimore  5. Sex 7. Age (In yrs.	last birthday,	4b. City, Town, or Baltin		8. Date of Birth (Month, Day, Y	4c. County of Deat	
	Director		215-16-7424 Usual Residence of Decedent	1 M 2 □ F 8	31 Yrs.	Indiana Sayo		AUG.8,19	22	MD
	death with the Maryland ms 23a or 28a-f show result be rediffed at	)r	10a. State 10b. County		y, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ain with the Marylan 23a or 28a-f show ust be notliffed at	Director	MD 10e. Street and Number	BALTIMORE	BAL	TIMORE 10f. Zip Code		10g	. Citizen of What Co	
	238 o		3119 NORTHBROOM				21208			U.S.A.
۰	ours affer rel', or Ite Exercitive	by Funeral	11. Marital Status 1 □ Never Married 2 🗖 Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 (X) Yes. 2 □ No WW If Yes, Give Year or Dates: KORE	111	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🕅 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
	in /2 hours "naturel", Loical Ex	ojeted	15. Decedent' (Specify only highest	grade completed)	16a. Dece (Give life.	edent's Usual Occupa e kind of work done d DO NOT use retired)	tion uring most of work	sing 16	b. Kind of Business/	industry
717	ed within rgiene. er than " t, the Mas	Completed	Elementary/Secondary (0-12)	5+ College (1-4or 5+)	INTER				ME	DICINE
	lid be fill lental Hy ked oth Ic even	Be	17. Father's Name (First, Middle, L BENJAMIN	ast)	BERMA	AN	18. Mother's Nam LENA	e (First, Middle, Mai	iden Sumame)	НҮАТТ
ary	and Me	10	19a. Informant's Name/Relationsh		19b. Maili	ing Address (Street a	nd Number or Rur			(ip Code)
ĕ ,	s 1 and 2 f Health Item 27 I		MILDRED BERMAN		_	L9 NORTHBR			ORE, MD 2	
	Page nent o ant: If ary or		1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp	3 □Removal from State BE	emetery, cre TH JA(	matory or other place	RY 2/9/	2004	FINKSBURG	, MD
<u>a</u>	Departr Departr Importe any Inju		21. Signature of Funeral Service L	consecution with		2. Name and Addres 3900 REIST				
	nysician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)		morr		, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner  Pu	Examiner	Sequentially list conditions,  ause. Enter Underlying Cause (Disease or injury that initiated events  c.							34 days
68/60,	incate be executed g physician and as the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a consequence of d.	uence of):					
DOX.	death cert e attending d for use a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
ras, r	requires that the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to death but not resu	ulting in the u	inderlying cause give	n in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to 2 □ No 3 □ Pro	
	i: Ineliaw re cate has bel : page 2 sho	Completed						24a. Was an autopsy performed 1 ☐ Yes 2	prior to o death?	topsy findings available ompletion of cause of
 	s certifi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	ER/Outpatier	nt 3 DOA Othe		h <i>(Check only one)</i> me 5 ☐ Residence	e 6 □Other (Spec	ifv)
io uoi	To the hours after the law within 24 hours after death within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: T	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work		28d. Describe how i		.,,,
DIVISION	iei or Atte s after de al Directo ed in by th	Certification:	3 Suicide 6 Could no 4 Homicide determin		me, farm, st	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
	ne Hospi n 24 hour he Funer stetety filk	edical	29a. Certifier Certifying (Check only one) Certifying	Physician: To the best of my know xaminer: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the time evestigation, in my op	e, date and place, inion, death occurr	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the comp	Ž	29b. Signature and title of certifier			29c. License			Date signed (Month	
	0,		30. Name an divress of person w	ho comp eted cause of death (Item	23a) (Type.	Print)	5-00C	> Feb	ruary lo,	2004
			JENNIFER J.	ADAMS MD	SINF	H. HOSPIT				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 11 2	Registrar's Signal	ture .					

		1 - For State RegistracAMEND ITEM 20	a-c&22 PER F					and Mental I	Hygien Reg. N	4004	03987
Physic /Medi Examir	cal	Decedent's Name (First, Middle, La     LE L	BUR	10	N	4b. City, Town,	or Location	2, Date of Month	VAT	ay Year 1001 c. County of Death	3. Time of Death 3: 22/M
Funeral			Sex 7. Ag	ville le (In yrs. Ia		If Under 1 Yea			f Birth	Carroll 9. Birtho	place (State or Foreign
Director		Usual Residence of Decedent	1□M 2ĂF	77	Yrs.	Months Days	s Hours	24 Hrs. 8. Date o Min. (Month May 2	79		yland
e Marylar 3a-f show tiffied at	Director	10a. State 10b. County  MD Carro	11	10c. City,	Syke	cation sville					1 ☐ Yes 2∑ No
uth with the 23a or 24 ust be no	al Dire	10e. Street and Number 7309 2nd Avenue	1			10f. Zip Code		21784	10g. C	itizen of What Cour USA	ntry?
I X I 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 2 Yes 2 1 If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 No.		igin? (Specify Yes o n, Puerto Rican, etc.	r No- )	14. Race - Americ Black, White, Specify: Whi	etc.
IZIS-UUSB vithin 72 hours af ne. han "natural", or ne Medical Exam	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	(Give life.	dent's Usual Doct kind of work don DO NOT use retir	e during mos red)	it of working	16b.	Kind of Business/In	
Maryland 21 d 2 should be filed w th and Menta Hygier th amarked other th traumatic event, La	To Be Co	17. Father's Name (First, Middle, Las John Grover	(t)		cu	stodial	18. Mothe	er's Name (First, Mid lia Eiche			system
- a - a -		19a. Informant's Name/Relationship Alice Burton/sis				•		er or Rural Route No White Ma			í
<b>Baltimore,</b> permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ( 1 4 ☐ Donation 5 X Other (Special Control of Control			LAND (	sition (Name of natory or other pl	į.	Date 2/13/04 by EVANS EUNI	BA	Location - City or To	
Cate be executed hysician and hysician and the burial-transit the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c. Due to (or as d	a conseque	ence of):	Allen Lojic	1)11 1)11 1. C.A.	7 FAI 2 [N 2) 10VA 315	CAN.	NE CION COM	Onset and Death  Reference  Sometime
the death certification by the attending plantached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3□	Ectopic pregnant Other (specify)	су		_	23d. Date of delive Month	ery Day Year
_ 2 B	ğ	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cause g	iven in Part I			use contribute to th	
	Completed							a	Vas an lutopsy enformed? es 2.⊒√N	death?	psy findings available mpletion of cause of
99 10	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No			R/Dutpatien	t 3 DDA	ther: 4 Nu	of Death (Check or	Residence		v)
r Attending ler death.	Certification;	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatic 3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	be 28e. Place of Inj		28b. Time of Injury ne, farm, str	M 1[	ork? ⊒Yes 2.□	No 28f. Locatio		ury occurred and Number or Rura se)	l Route Number,
spital ours a leral I	Medical Ce	29a. Certifier 1 Certifying P (Check only one)	hysicien: To the best miner: Dn the basis of and manner sta	f examination	ledge, death on and/or inv	occurred at the vestigation, in my	time, date an opinion, dea	d place, and due to th occurred at the ti	the cause(s	s) and manner as st nd place, and due to	ated. the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1	- 1 B	100	29c. Licer	se number	9/1	29d. Da	ate signed (Month,	Day, Year)
6		30. Name and address of person who	completed cause of d	leath (Item:	23a) (Type.	Print)	MI	US, A	100	2-111	) way
St. Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signatu	ire	alsi P	,				

	-	For State Registrer	State	of Maryla	and / Depa <i>Cei</i>	artment of H	lealth and Death		iene200	4 03988
Physicia		1. Decedent's Name (First, Midd.						2. Date of Deat		3. Time of Death
/Medica	al .	Betty Lou 1						Februar	у 3, 2004	3:30 AM M
Examine	r	4a. Fecility Name (If not institution Carroll County			r	4b. City, Town, or Westmin		eath	4c. County of De	
Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 H	Hrs. 8. Date of Birth		Sirthplace (State or Foreign
Director		213-34-5111	1 □ M 2 <b>X</b> F	67	Yrs.	Months Days	Hours N	Hrs. 8. Date of Birth (Month, Day, Dec 23,	1936 W	Co <i>untry)</i> est Virginia
and and	-	Usual Residence of Decedent  10a. State 10b. County	-	10c. (	City, Town or Lo	cation				10d. Inside City Limits
Mary I sh	ō	MD Carr	·o11		Ham	pstead				1 ☐ Yes 2√ No
or 28g	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What	Country?
s 23a	E E	3825 Shiloh Av					1074		USA	
ter de Ittems	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 ☐ Mar</li> </ol>	Armed F	cedent Ever in orces? 2 1 No	U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
ours at	2	3 XWidowed 4 Divorced	If Yes G	ive		I∏ Yes 2∭ No	Specify:		Specify:	white
at yielild XIXI3-0030 should be filed within 72 hours atter death with the Maryland nd Mental Hygiene. nasked other than "natural", or items 23a or 28a-f show umatic event, it a Madical Examitation was the natified at	Completed		nt's Education st grade completed	)	16a. Deced	ient's Usual Occupa kind of work done of OO NOT use retired	ation furing most of t	working	16b. Kind of Busines	ss/Industry
within the the the the the the the the the the	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. L					
Hygin other sent, I	o l	17. Father's Name (First, Middle,				nurses		Name (First, Middle, M		pitals
uld be Wenta wrked urked	0	William Lied	ly				Vers	ie Lewis		
2 sho and I is ma		19a. Informant's Name/Relations						Rural Route Number,		, Zip Code)
T and 1 and Health em 27 ther to	-	Darlene Peters	daugn		. Place of Dispos	Appropriate Control of the Control o	street	Lineboro,		Town State
perinition (e.) Intelligible ATA 13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examinational prices.		1 ☐ Burial 2 ☐ Cremation • 4 ☑ Donation 5 ☐ Other (S	Specify)	State	cemetery, cren	natory or other place			20c. Location - City o	
Dermit Depart Import any in		21. Signature of Funeral Service Ronald	Licensee Wade,	Directo		Name and Addres ate Anato ltimore.		rd 655 W.	Baltimore	Street
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de each line.	ath. Do not ente	er the mode of dying	, such as card		st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a C	OPD						Onset and Death
/Medical Examiner			Due to	(or as a conse	equence of):					1
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a conse	equence of):					
executed in and ial-transit	all	that initiated events	c							
		resulting in death) Last	Due to	(or as a conse	equence of):					
physics the t	adicai		d							VIC-1/4
death certific	rnysician/me	IF FEMALE: 23b. Was decedent pregnant		tcome of preg					23d. Date of d	elivery
iries that the death cer signed by the attendin d be detached for use	SICIA	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Fe nant at time of		Ectopic pregnancy Other (specify)	-		Month	Day Year
d by the letach		9 □Unknown Part II. Other significant condition	-		andting in the con-	<b></b>	- 1- <b>D</b> - 41	oon Didank		
w requires t	0	- arrin other signmount contain				Cenying cause give	mmranti.			to the cause of death?  robably 4  Unknown
To the Hospital or Attending Physician: The law requires that the death certification is the Funeral Director: Atter this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	completed							24a. Was an autopsy perform 1 Yes 2	ed?, prior to	autopsy findings available completion of cause of
cian: ertifica ector,	a)	25. Was case referred to medical examiner?						Death (Check only one		
Physical direction		1 Yes 2 No  27. Manner of Death			☐ ER/Outpatient 28b. Time of		4   Nursing	Home 5 Resider		ecify)
ding.	5	1 Aatural 5 ☐ Pendin 2 ☐ Accident investig		of Injury oth, Day Year)	Injury	28c. Injury Work M 1 7	at ? ′es 2∐No	28d. Describe how	v injury occurred	
tal or Attending P is after death.  al Director: After ed in by the funer?	2	3 Suicide 6 Could	not be	e of Injury - At	home, farm, stre	et, factory, office	-	28f. Location (Stre	et and Number or F	Rural Route Number,
ital or rai Dir			10					City or Town,		
To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifyin (Check only one) 2 Medicel	exeminer: On the c	e best of my kr pasis of examin nner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my op	e, date and pla inion, death oc	ace, and due to the car courred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
withi To tl		29b. Signature and title of certifie	1	~	\	29c. License	number	29	d. Date signed (Mor	ith, Day, Year)
	-	Nome and address	Sent	1	Om (23c) (T	10000	192-	- Fe	bruary 3	12004
	1	30. Name and address of person  Levider P. H. Ca	AP/SOA	- Company	am 23a) (Type, F	Mancha	Her R	I Man	h 1/2 - 1/	402162
State		31. Date filed (Month, Day, Year)	32. F	Dadistanda Cias	nature	Coull o		17 1 - 401-10	Ve XI TO V	
Registra		FEB 1	1 ZUU4	STANLE S	Li A					

State of Maryland / Department of Health and Mental Hygiene 2001

				Otato or ivial	ylana		ificate of		R	eg. No.	4 03989
	Physicia	an	1. Decedent's Name (First, Middle, La		401	RON			2. Date of Deel Month	th Day Yea	3. Time of Death
N. S. S. S. S. S. S. S. S. S. S. S. S. S.	/Medic Examin	al	4a Fecility Name (If not institution, giv	.0 - 0.	1/2			4b. City, Town, or I	Location of Death	4c. County of De	Dath
		о. —	The Wood L		SIST		MIN91	BAUTI	MURE	BALT	IMORE_
ı	Funeral Director		5. Social Security Number 258-01-5170 6. S	Sex 7. Age ( I□M 2XIF	(In yrs. le. 88	st birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey) Aug 19,	1915 Ge	sirthplace (State or Foreign Country) Orgia
	pue *		Usual Residence of Decedent  10a. State 10b. County	1.	10c. City.	Town or Loca	ation				10d. Inside City Limits
	Maryl -f sho	to	MD Baltime	ore		Baltim	ore				1 ☐ Yes 2)(☐ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What	Country?
	ne 23e	erai	1320 Windlass Dr:	12. Was Decedent Ev	er in U.S.	. 13. W		. 220 Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - An	nerican Indian,
21215-0020	within 72 hours eftar death with tha Maryland ana. than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Yes, specify Cub □Yes 21X No	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black, Wi	white white
15-(	n 72 h natu	etec	15. Decedent's Ed (Specify only highest gre	fucation ide completed)		16a. Decede (Give ki	nt's Usual Occup ind of work done O NOT use retire	eation during most of wor d)	king	16b. Kind of Busines	s/Industry
212	d withi	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)			elf emp			driving s	chool
pue	should be filad withind Mantel Hygiana. merked other than	Be	17. Father's Neme (First, Middle, Last,				unk	18. Mother's Nan	ne (First, Middle, M	Maiden Sumame)	unk
Maryland	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	ဥ	19a. Informant's Name/Relationship ( Rodney Renner							; City or Town, State	
Baltimore,	0 P E E		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Pla	ce of Disposi netery, crema	tion (Name of tory or other plac	ce) I	Date	20c. Location - City of	or Town, State
Him	permit. Pages of Popartment of Plimportant: if Ita any Injury or of once.		4 ☐ Donation 5 🕅 Other (Specification)	y) in state		22	Name and Addre	es of Facility			
Ba	Depa Impo any i		21. Signature of Funeral Service Licer RODA LOS	Wate Direc	ctor		ite Anat Ltimore,	-		Baltimore	Street
			23a. Part1. Enter the disease, of com shock, or heart failure. List only	plications that caused thone cause on each line.	ne death.	Do not enter	the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
_}	Physician /Medical		Immediate Cause (Final disease or condition	Poor	ly	Dille	rentia	ked Lar	y cell	Lympha	e an-Kirom
Н	Examiner	_	resulting in death)	a. Dı	ue to (or a	s a copsequ			<i>(</i> /	1	1
	outed Id ansit	Examiner	Sequentially list conditions	b	ue to (or a	is a conseque	ence of):				
60,	ficeta be executed physician and is the bunal-transit	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	C							1
68760,	tificeta ig physi as the	Medical	that initiated events resulting in death) Lest	Du	e fo (or a	s a conseque	ince of):				
Вох	eath cer ettendin for use	lan		d							1
P.O.	tha deay the eached f	Physician/	Part II. Other significant conditions of	_				en in Part I.			te to the cause of death?  Probably 4 Unknown
s, P	ss that gned b	2	A duance Chronic	9 1	em	and 10	1	•		2010 00	, rocasi, 45 circum
Division of Vital Records,	law requires that tha death certificeta be executed as been signed by the ettending physician and a 2 should be detached for use as the burial-transit	Completed	Chronic	Moln	N	uh	an		24a. Was ar perform		Were autopsy findings available prior to completion of cause of death?
Re	0 - 5	ошо							1 🗆 Yu	5 21/10	of death? 1 □ Yes 2 ☑ No
/ital	ysician: The is certificete director, par	Be	25. Was case referred to medical examiner?	Hospital:			015		th (Check only on	θ)	4 - 5 - 1
<del>f</del> o	S s D	<u>د</u> ا	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2	NOutpatient 8b. Time of	3□ DOA Oth	+ □ Nuising ⊓		nce 6 Other (Sp w injury occurred	Limit
ion	eth. vr. Afte ha funs	ation	1 Naturel 5 Pending investigation		(ear)	Injury		k? Yes 2□No			0
Divis	al or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At hom (Specify)	e, farm, stree	t, factory, office		28f. Location (Sti City or Town	reet and Number or i , State)	Rural Route Number,
	Hospi 4 hou Tuner aly fill	edical	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of n niner: On the basis of ex and manner stated	caminatio	edge, death on end/or inve	ccurred at the tin stigation, in my o	ne, date and place, pinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the Position 2 To the Complate	Σ	29b. Signature and title of certifier	D			29c. Licens	e number - 3 8 7-5	54	9d. Date signed (Mod $O(-22)$	nth, Day, Year) -2004.
			30. Name and address of person who	completed cause of deat	th (Item 2	3e) (Type, Pr	int) BAS	TERN	BLV	D-MD	-21221
	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 1 20	32 Registrar's	Signatur		the				

DHMH 16 Rev 6/95

			For State	State of Marylan	•	ent of Health and ate of Death	Mental Hygie	_ / UUU	03990
			Registrar  1. Decedent's Name (First, Middle, Last	)		,	2. Date of Death		3. Time of Death
	Physici		Janetle			Carter	Februar	Day Year 6, 2004	20:00 M
·	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	City, Town, or Location of Dea	th	4c. County of Death	1
÷.			JOHNS HOP	KINS HOSPI	TAL S	GALTIMORE	CITY	NI	A
	Funeral Director		5. Social Security Number 6. Se 15	7. Age (In yrs. )	last birthday) If Ur A Yrs. Mont	nder 1 Year   If Under 24 Hrs hs Days   Hours   Min		9. Birth Col.	nplace (State or Foreign untry) HIO
	P.		Usual Residence of Decedent	100 Cit	y, Town or Location				10d. Inside City Limits
	show	<u>_</u>	10a. State 10b. County			0 - 1./// 5			1⊠Yes 2 No
	28e-f	ecte	OHIO STEUBE	VVILLE		UBENVILLE Zip Code	10g.	Citizen of What Cor	untry?
	3a or	۵	<b>^</b> . <b>^</b>	D AVENUE		4395	2	USA	
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puel	Specify Yes or No-	14. Race - Amer Black, White	
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23e or 28e-f show simportants if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modical Examination contact.		1 Never Married 2 Married	1 ☐ Yes 2 Z No If Yes, Give		s 2⊠ No Specify:	10 1 110411, 0101,	Specify: 2	002
ë	tural'	ed by	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	16a. Decedent's t	Jsual Occupation	166	o. Kind of Business/I	ACK ndustry
215-0036	ain 72 n "na	Completed	(Specify only highest grad		(Give kind of	work done during most of wo Tuse retired)	rking /		,
212	giene giene er the	E O	Elenierically/Secondary (0*12)	/	MEDICA	-L ASSISTANT/	TLERK P	4 ySICIAN	IS OFFICE
	be filed ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)	/	0	PT 1 0	me (First, Middle, Mai	derl Sumame)	,
Maryland	2 should be filed and Mental Hygi is marked other aumatic event,	은	CHARLES	HERMAN	CARTE	ress (Street and Number or R	L. /		in Code)
Z	d2st thanc than traun		19a. Informant's Name/Relationship (T)	(5,	1.00	ARFIELD AVE		VILLE OHI	NAGES
	Health tem 27 other tr		20a. Method of Disposition	20b. P	Place of Disposition (	Name of		. Location - City or 1	
e E	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  * 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	1	METERY 02-	12-04 51	FIMEN VILL	E. 0410
Baltimore	permit. Pag Department Important: I sny injury o		21. Signatur of Funeral Service Licens	The second second		and Address of Capilles			ERAL HOME
<u> </u>	896 28			1.10m	J 37.	98 N. FULTO	NAVE, B.	ALTO, MD.	21217
F			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the death ne cause on each line.	h. Do not enter the	mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a acute r	espira	tony distr	in ayu	& home	3 neery
	Examiner			Due to (or as a consequence of the second of	uence of):		,		3 wells
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ			12		2
	cuted nd ransit	Examiner	that initiated events	. netticillir	1- ren3+	fant 5-1	your	is freeze	is Sween
ဂ္က	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):	27	2.1		
8760,	the the	dical		d					
× 6	certific Iding I	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incy			23d. Date of deliv	/erv
Вох	that the death certificate ed by the attending physi detached for use as the	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩No	1☐Live birth 2☐Fetal 4☐Pregnant at time of de		c pregnancy (specify)		Month	Day Year
P.O.	tithe oby the tached	hys	9 Unknown	9□ Unknown			10-		
Ś	90 PG	by P	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	ng cause given in Part I.	23e. Did tobac	co use contribute to	
ord	w require been si should	ted							
Sec	e law has b je 2 sl	Completed					24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
a	n: Th ficate rr. pag	e Co	25. Was case referred to medical			00 70 10	1 X Yes 2 □		2. No
5	/sicia s certi firecto	To Be	evaminer?	Hospital:   X Inpatient 2	ER/Outpatient 3	Other	ath (Check only one)  Home 5 Residence	e 6 ∏Other (Spec	ity)
) of	g Phy ier thii neral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i		
Ö	ttendin death. stor: Afi / the fur	atio	Natural 5 Pending investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	м	1 ☐ Yes 2 ☐ No			
Division of Vital Record	or Atter de Direct	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fac y)	ctory, office	28f. Location (Stree City or Town, S		ral Route Number,
_	spite hours unerel y fillec		29a. Certifier Certifying Phy	sician: To the best of my kno ner: On the basis of examinat	wledge, death occur	red at the time, date and plac	e, and due to the cause	e(s) and manner as	stated.
	To the Ho within 24 To the Fu	Medical	one)	and manner stated.	nion and/or myestiga				
)	To To Con	-	29b. Signature and title of certain	1/ 1	111	29c. License number	29d.	Date signed (Month)	. Day, Year)
	8		20 Name and address of access it	ompleted course of death (!	23a) (Tuna Brief)	Les-000	, Fe	brian	6,2004
	1		30. Name and address of person who co	SILEVA 600	North 1	volte Stree	+ Raltim	ore un	21287-910
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	ish a			

ORIGINAL

			_ FOI	Department of Health and N	Mental Hygien	e2004 03991
			1 - State Registrar	Certificate of Death	Reg. N	
	Physicia	in	Pecedent's Name (First, Middle, Last)	Collins	2. Date of Death Month Directory	3. Time of Death 4:39 PM
N. C.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	01104	c. County of Death
	<u> </u>		Do has Hopkins Hospita	L Baltimar	e city	NIA
	Funeral Director		5. Social Security Number 16. Sex 7. Age (Intyrs, last b)	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country) MARYLAND
	pu »	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tov	wn or Location		10d. Inside City Limits
	sho	ō	and District	BAITIMAR	E CITI	/ 1ÆYes 2□No
	the N	rect	10e. Street and Number	10f. Zip Code	109.	Citizen of What Country?
	3a or	0	241 S. HERRING (D	URT 2123	1	USA.
	death	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other than "natural", or Items 23s or 28s-f show svent, the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 🗖 Married 1 ☐ Yes 2 🗖 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: BI ACIL
3	2 hou	ted	15. Decedent's Education 16a	a. Decedent's Usual Occupation (Give kind of work done during most of work	18b.	Kind of Business/Industry
215-0036	thin 7.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	(iii)	11/2
7		Con	12HGRADE	UNEMPLOYED	ne (First, Middle, Maide	N/A
ğ	ould be filed with Mental Hygier Briked other the Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute Bric sysnt, Institute British Bric sysne, Institute British Britis	Be	17. Father's Name (First, Middle, Last) (( NKNOWN)	18. Mother's Ivalia	ATTICLE	(TO A/ES
Maryland	should be filed within of Mental Hygiene. marked other than amatic event, Italia	ဥ	19a. Informant's Name/Relationship (Type, Print)	b. Mailing Address (Street and Number or Rus	ral Route Number, City	or Town, State, Zip Code)
<u>8</u>	and 2 s ealth an n 27 ls.		BRIAN COLLINS (HUSBAND)	2415 HERRIA	IG CT. Y	BALTO, MD 21231
ē,	of Hea of Hea fitem		20a. Method of Disposition 20b. Place	of Disposition (Name of ery, crematory or other place)	Date Oc.	Location - City or Town, State
altimore,	Pages nent of ant: If it ary or o		1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify)	RO CREMATORY 02-	11-04 B	ALTIMORE, MARYLAND
a	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Foreral Service Licensee	22. Name and Address of acility	BROWN	JR. FUNERAL HOME BALTO, MD 21217
m	207	70. 0	Vietter V. Villand			BALTO, MD. 21217
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	onot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Wo I boths
	Examiner		Dué to (or as a consequence	→ OT):		Three Months
66.0	* # 4	Jer	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence	B of):		
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
Ö,	e exe		resulting in death) Last Due to (or as a consequence	a of):		
8760,	icate be executed physician and s the burial-transit	dical	d			
9	ding p	w	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	Physicien: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use ar	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	t the c by the	hys	9 Unknown		The state of the s	
	es tha gned be de	by P	Part II. Other significant conditions contributing to death but not resulting	Laidonia		o use contribute to the cause of death?
Division of Vital Records,	w require been sign	ted	Type I Rexul Introduct A		1 Tes	
ec	s law i	Completed	Kecurrent Clostriaium	Vitticile Diame	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
E	r. The				1 Yes 2 X N	
<b>#</b>	sician	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: Inpatient 2 ☐ ER/C	Other	th (Check only one) ome 5 Residence	6 DOther (Specify)
o	Phy er this		27. Manner of Death 28a. Date of Injury 28b.	. Time of 28c. Injury at	28d. Describe how in	
<u>o</u>	Attending ir death. ector: After by the fune	atio	1 XNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		
<u>×</u>	or Attsnd after death Director: A	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	ital o urs aft ral Di					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier  (Check only one)  Check only 2 Medicaf Examiner: On the basis of examination a and manner stated.			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
>	C > F 0		De Mo	RES-000	for	niary 6.200+
	7		30. Name and address of person who completed cause of death (Item 23a	() (Type, Print)	+ Raltin	000 000 0.000
	U		31. Date filed (Month, Day, Year) 32. Registrar's Signature	TWITH WOITE SIFEE	1 Daniery	WE, 114 21261
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	10 L. 10.		

		For Unpend Item#23a,2	State of Maryler,	0626.2 Ce	713764 rtifica	te of Dea	h and N th		ene 2	004	03992
Physicia		Decedent's Name (First, Middle, Last)				/		2. Date of Death Month	Day	Yeer	3. Time of Death
/Medica	al -		JICOLE	COLE				Februar		2004	0613 P. <sup>M</sup>
Examine	er	4a. Fecility Name (If not institution, give st	111		4b. City	Town, or Locati			4c. Cou	unty of Death	4
*		Johns Hopkins Hosp: 5. Social Security Number 6. Sex	1Tal 7. Age (in yrs.	last hirthday)	If Unde	Balti riYear IfUn	MOTE der 24 Hrs.	8 Date of Birth		9. Birtho	A place (State or Foreign
Funeral Director			M 212 3	2 Yrs.	Months			8. Date of Birth (Month, Day	Year) 71	Cour	YLAND
		Usual Residence of Decedent						DCC. O.D			
nylan lhow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation		/			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
Ba-f a	Directo	MARYLAND NIA	13.	ALTII.			174				
vith th		10e. Street and Number 1632 BRUCE	07		101. 21	Code	7	10	g. Citizen	of What Cour	itry ?
death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral		2. Was Decedent Ever in U	IS 13	Was Dece	dent of Hispanic	Origin? (Sr	ecify Yes or No-	14.	Race - Americ	can Indian.
after d	Fun	11. Marital Status 12 Never Married 2 Married 12	Armed Forces? 1 ☐ Yes 2 ☑No		If Yes, sp∈	cify Cuban, Mex	tican, Puerto	Rican, etc.)		Black, White,	
hours at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 ¥No Spec	city:		Spe	ecify: B	ACK
ITIO 6 16 15 - UOSO  De filed within 72 hours after death with the Marylan Ital Hygiene. Ital Hygiene. Ital Hygiene at the matural, or itams 23a or 28a-f show avent, the Medical Examinat must be notified at	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	kind of w	al Occupation ork done during r	most of work	ang 1	6b. Kind o	of Business/Inc	dustry
dithin att	d l	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT L	ise retired)			2007	AUR	PAIT
lied w tygies ther ti		17. Father's Name (First, Middle, Last)		('DO		18 M	other's Nam	e (First, Middle, M		,,,,,,,,,	, ,,,,,,
d be fill antat H ced oth	Be	JOHNNIE	5	KINK	ISR		TLER.			10/8/	MAN
ie, Maryiar 1 and 2 should be 1 Health and Menta 1 Health and Menta 1 tem 27 Ia marked other traumatic a	ဥ	19a. Informant's Name/Relationship (Type						ral Route Number,	City or To	wn, State, Zip	Code)
and 2 and 2		VALERIE MACK	(MOTHER)	1638	2 B	RUCE C	T., B,	ALTIMOR	EM	nD S	21217
		20a. Method of Disposition	20b. i	Place of Dispo cemetery, crei	sition (Na	me of other place)	1	Date 2	0c. Locati	on - City or To	own, State
Dallimor Department of Important: if it any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)		TRO C	REM	ATORY	02-	11-04 B	ALTI	MORE,	MARYLAND
Dallimo permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licensee		22	Name a	nd Ad ress of Fa	acility BR	sun JR.	Fun	JERAL	HOME 10.21217
20529		Vi artich IV. I	Luam.							LTO. 1	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deal cause on each line.	th. Do not ent	er the mo	de of dying, such	as cardiac	or respiratory arre	St,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Narcotic Intox							-	
Examiner	1		Due to (or as a consec	quence of):							
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):							
outed	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.									
be executed ician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):							
6 × 8	lical	d.									
death certificate at the for use as the	Med	IF FEMALE:	c. If yes, outcome of pregna	ancy					004	Data of dalling	
BOX sath cer attendir for use	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic p				230.	Date of delive Month	Day Year
ithe d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown								
requires that seen signed be hould be deta	by Pt	Part II. Other significant conditions conti	ributing to death but not res	sulting in the u	nderlying	cause given in Pa	art I.	23e. Did toba	acco use o	contribute to th	ne cause of death?
quire an sig								1 🗌 Yes	2 □ N	o 3□Prob	ably 4 Únknown
necords he law requires has been sign ge 2 should be	plet							24a. Was an autopsy		b. Were auto	psy findings available mpletion of cause of
The law sate has be page 2 s	Completed							perform Yes 2	ed?	death?	2□ No
VICAL MEC sicien: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?					lace of Dear	h (Check only one	2		
OI VITA Physician: this certific ral director,	ို	IN THE Z NO		ER/Outpatier			Nursing H	ome 5 Resider			γ)
After fune	on	27. Manner of Death  1 Natural  5 Pending	28a. Date of Injury (Month, Day Year) 2/4/04	28b. Time of Injury		28c. Injury at Work? 1 ☐ Yes 2	P FWNo	unknown	v injury oc	cuired	
or Attending after death. Director: After in by the fune	licat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	unknown ome, farm, str	-			28f. Location (Str.	et and Nu	umber or Rura	I Route Number,
affer affer din b	Certification	4  Homicide	huilding, etc. (Special House	fy)				220 S. Ea		Baltir	nore, MD
	edicai C		cian: To the best of my knows: On the basis of examina and manner stated.					and due to the car	use(s) and	l manner as st	tated.
within To the Comple	Me	29b. Signature and title of certifier			29	c. License numb	oer nec			gned (Month,	
D.O.		Y Llorhe	aul			OCME		Fe	ebrua	ry 5,	2004
Javon	1	30. Name and address of person who cont	cause of death (Iter	m 23a) (Type,							
0 %		J. LATON LOCK	=(M)		1	11 Penn	Stree	t, Baltir	nore,	Maryl	and 21201
		31. Date filed (Month, Day, Year)	32. Segistrar's Signa	advisor.	me						

			For State	State	of Marylan		artment of H		Mental Hygie	ene 200L	03993
			1. Decedent's Name (First, Middle	, Last)					2. Date of Death		3. Time of Death
	ysicia		Ella Mae C	ushman					February	Day Year 7 9 2004	1:10 AM
	Medic ramin		4a. Facility Name (If not institution	give street and nu	ımber)		4b. City, Town, or	Location of Death		4c. County of Deat	
			307 Tall Pi	nes Ct.			21009			Harf	
	eral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)
Dire	ctor		220-20-1635 Usual Residence of Decedent		76	113.			Dec. 15,	1927 Ma	ryland
land	=	1	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
Mary -fah	fled	to	Maryland Harfo	rd	A	bingdo	n				1 □ Yes 🍇 🖔 No
h the	ruot	Director	10e. Street and Number				10f. Zip Code		10g	. Citizen of What Co	untry?
th will	4		307 Tall Pines				2100			USA	
ar dea	er u	Funeral	11. Marital Status	Armed F		S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
s afte	and a	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ∐ Yes If Yes, G Year or I	2 <b>∑</b> No ive ⊃ates:		1 ☐ Yes 2½ No	Specify:		Specify: W	hite
d KIKI 2-00000 filed within 72 hours after death with the Maryland Hygiene. Then natural', or Itama 23a or 28e-f ahow	SalE	ed	15. Decedent	's Education			tent's Usual Occupa		. 16	6b. Kind of Business/	Industry
n 72 C	Medi	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed,	(1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired	furing most of worl )	ang		
d with	2	Completed	Light Control of Contr	2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Secr	etary			J.S. Gover	nment
al Hy	event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, I						e (First, Middle, Ma		
2 should be filed within and Mental Hygiene.	atic	ပ္	Joseph (nmn)	Cushmar				Bertha		inkler	Tin Contail
E to C E	traumatic		19a. Informant's Name/Relations? Charles E. Pol							City or Town, State, 2 21162–0143	up Code)
permit. Pages 1 and 2 Department of Health a	ther		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	100		c. Location - City or	Town, State
Pages nent of ant: If its	7 01 0		1 Burial 2 Cremation 4 Donation 5 Other (St	3 Removal from	State		natory or other place Service C		3-04 т	Yowson, Ma	ryl and
mit. P.	injur,	i	21. Signature of Funeral Service	4 1			Name and Addres			.Owson, Pa	LYLURA
permit. Departr	any ir		NA 10, 111	Campa	1m	M 1	cComas Fu 317 Cokes	ineral Ho Burv Rao	me, P.A. d. Abingd	on, Maryl	and 21009
30			23a. Part1. Enter the disease, or shock, or heart laifure. List	complications that	caused the death						Approximate Interval Between
Physic	cian		Immediate Cause (Final disease or condition			tati	c Luw	va Co	incor	3	Co wonths
/Med	lical.		resulting in death)	Due to	(or as a consequ			J			
Exam	iner		Sequentially list conditions, if any, leading to immediate	b. — Due to	(24.22.2.22222	ionae afti					
p	sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	derice or):					
be executed icien and	al-trar	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):					
e be ex	for use as the burial-transit	cal		d							
ufficat g phy	as th										
th cer	esn .	by Physician/Med	1F FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnancy			23d. Date ol del Month	ivery Day Year
e dea	of ber	sici	in the past 12 months?  1 Yes 2 No	4□Preg 9□Unki	nant at time of de nown	eath 5□	Other (specify)			Worth	52,
nat the d by t	should be detached for	Phy	9 ☐ Unknown  Part II. Other significant condition	ns contributing to	teath but not resu	ulting in the u	nderlying cause give	en in Part I	23e. Did toba	cco use contribute to	the cause of death?
Loy, lires the signe	peq		Part II. Other significant conduct	and continuously to	30411 201 1101 1001	, in ing a 1 a 10 o	noonying according	2011	1 Tes	2 □ No 3 □ Pr	obably 4 Unknown
y requ	should	Completed							24a. Was an	24b. Were au	itopsy lindings available
ne lav	96 2	mp							autopsy performe	prior to death?	completion of cause of
VICAL F ician: Th certificate	or. pa	e Co	25. Was case relerred to medical					26. Place of Dea	th (Check only one)	PNo 1 □ Yes	2□ No
ysicia	direct	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatien	it 3□ DOA Othe			ce 6 □Other (Spe	cify)
g Phy ter this	funeral director, page 2	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time of	28c. Injury Work	at c?	28d. Describe how	injury occurred	
VISION Attending r death.	he fu	atic	2 ☐ Accident investig	ation				Yes 2 □No			
or Att	n by t	ertification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and 200. Flat	e of Injury - At ho ling, etc. (Specify	me, lam. str /)	eet, factory, office		281. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
UNISTICITIES AND THE COLORS, T.O. BOX 001  To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funarial Director: After this certificate has been signed by the attending phys	completely filled in by the	O	29a. Certifier , 1 Certifyin	g Physician: To th	a hast of my kno	wledge desil	occurred at the time	ne date and place	and due to the care	se(s) and manner as	stated
24 hc	etely	edical	(Check only 2 Medicel	Examiner: On the	basis of examinal nner stated.	tion and/or in	vestigation, in my of	pinion, death occur	rred at the time, date	e and place, and due	to the cause(s)
To the	сошр	Me	29b. Signature and title of certifier		m.D		29c. License			d. Date signed (Mont	
			) My		11(- U)	•	102	15390	FE	CUCHRY	9th,2004
3	D		30. Name and address of person MYO MIN(N.D	who completed cau	ise of death (Item	23a) (Type, 47WDO	Print) D ROAD	# Z00	BELAIR	S.CM,	1014
R	Sta egistr		31. Date filed (Month, Day, Year) FFB 1 1 2004		Registrar's Signa			<i>!</i>			
	J		LED I T COOL	/		/ /					

		1 - For State Registrar	State of Man	yland / Depa <i>Ce</i>	artment of F rtificate of	lealth and Death		Reg. No.	2004	03994
Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
/Medic		Raymond George Cr		,			Februa	-	2004	10811 AM
Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dear	h		County of Deat	h
		St Agnes Hea	Ithcare	ed La como de más brindhada col	If Under 1 Year	NOVE If Under 24 Hrs	8. Date of Bir		N/A	hplace (State or Foreign
Funeral		5. Social Security Number 6. Sex 216-28-1429	M 2□F	In yrs. last birthday) 71 Yrs.	Months Days	Hours Min		29 ear)	1932 M	aryland
Director		Usual Residence of Decedent								
/land		10a. State 10b. County	1	0c. City, Town or Lo	ocation					10d. Inside City Limits
Man	ţō	Maryland N/A		Baltimor	:e					1 ☐ Yes 2 ☑ No
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner musics mullish a once.	I Director	10e. Street and Number 3531 Wilkens Ave.			10f. Zip Code 21229			-	sen of What Co	ountry?
Jeath Tis 23	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No	)-	14. Race - Ame	
or ite	Fur	1 Never Married 2 Married	Armed Forces? 1 Types 2 □ No If Yes, Give	19/17-	1 ☐ Yes 2√∑ No	Specify:	to rican, etc.)		Black, Whit Specify:	
21215-0036 d within 72 hours at glene. er then "natural; or the Wid cal Exem	Completed by	3 Widowed 4 Divorced	Year or Dates:	1949	21					White
72 t	ete	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	orking	16b. Kir	nd of Business/	Industry
Mathin Mathin	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		Selecto				Food	Distributio
Hygie nt, m	e Co	17. Father's Name (First, Middle, Last)		1		18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
Maryland of 2 should be file th and Mental H) 27 is marked oth	To Be	Raymond Crouch				Emma W	alters			
Should Mind Mind	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Numb	er, City or	Town, State, 2	Zip Code)
Md 2 all a a grant a a gra		Dolores Crouch, w	ife	3531	Wilkens A	Ave. Bal	timore,	MD.	21229-	5106
or Lealth them 27 I to ther tree		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Lo	cation - City or	Town, State
Page Page nnt: If		1 XBurial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Loudon Pa		1	11-04	Ва	altimor	e, MD
Baltimore, permit. Pages 1 at Department of Hea Important: If them any injury or othe		21. Signature of Funeral Service License	99	_ 2	2. Name and Addre	ss of Facility	Home In	C		
m ggesa		Thopens	A Call		1328 Sul	ohur Spr	ing Rd.	Arhi	itus, M	n. 21227
		23 Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ASC	OV						Onset and Death Unknown
/Medical		resulting in death)	Due to (or as a	consequence of):						
Examiner		Sequentially list conditions,	o							
P / #	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a c	cons-quence of						
exaction and and and and and and and and and an	хап	that initiated events resulting in death) Last	Due to (or as a c	consequence of):						
	E E									
- U D	dical		1							
_ ≘ ⊙.a	Physician/Me	IF FEMALE:	3c. If yes, outcome of					2	23d. Date of del	ivery
Box eath cer attendin for use	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2 i 4☐Pregnant at tin		⊒Ectopic pregnanc; ⊒ Other <i>(specify)</i> _	<u> </u>			Month	Day Year
O	lsk	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□ Unknown							
F 5 5 5	by PI	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did 1	tobacco u	se contribute to	the cause of death?
rds, quires en sign uld be		Diabetes					10	Yes 2[	□No 3□Pr	obably 4 Unknown
Vital Records, sicien: The law requires t certificate has been signe irector, page 2 should be a	Completed						24a. Was			utopsy findings available completion of cause of
The lav	E O							ormed?	death?	_
	0	25. Was case referred to medical				26. Place of De	ath (Check only		<u> </u>	
> 00	To B	examiner? 1 🗆 Yes 🌠 No	lospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Ott	er: 4 Nursing	Home 5 ☐ Resi	dence 6	S □Other (Spe	city)
		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time (	Wo		28d. Describe	how injury	y occurred	
VISION Attending If death. ector: Afte	catle	2 Accident investigation				Yes 2 □No				
Division  or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, st (Specify)	reet, factory, office		28f. Location ( City or To			ural Route Number,
oital o		No. of the Control of								
Division To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	edical	29a. Certifier Certifying Phy (Check only one)  Certifying Phy Description	sician: To the best of oner: On the basis of example of manner state	xamination and/or in	th occurred at the ti ivestigation, in my o	me, date and place opinion, death occ	e, and due to the turred at the time,	date and	and manner as place, and due	s stated. e to the cause(s)
To the I within 2 To the Complet	Mec	29b. Signature and title of certifier	2	٥.	29c. Licens	se number		29d. Dat	e signed (Mont	h, Day, Year)
F 3 F 8		Munt	* n	11)	Do	5533	2	Fol	STUGAL	8,2004
K		30. Name and address of person who co	empleted cause of dea	th (Item 23a) (Type	Print)		0 1	160	die -	
-)			geler,	900 Co	Print) Lton Av	enue,	Baltin	ove,	MD 7	11229
St	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	/					
Regist	rar	FFR 1 1 2004	part	D	Anna Ko	/				

Crowch, Raymond G.

	49		1 - State Registrar	State	of Ma	yland	-	artmen tificat			and N	lental Hy	Reg. No	60	04	03	995
	Physici	an	1. Decedent's Name (First, Middle, L		JAV	; C						2. Date of De	Da	14 2 c/	Year		of Death
	/Medic		4a. Fecility Name (If not institution, g					4b. City.	Town, or	Location o	of Death	yanu		c. County	of Death		- //
	Examin	er	BON SECOU		Lospi	TAL			eden.	TIMO			,	Balt:	imor	2	
	Funeral			Sex 1 M 2 F	7. Age	*	st birthday) Yrs.		1 Year Days			8. Date of Bi (Month, Di June 2	rth ay, Year,	966	9. Birth Cou	place (Stet ntry)	e or Foreign rolina
	Director		Usuel Residence of Decedent									Journe 2		3001	1101		1011110
	yland 10w		10a. State 10b. County			10c. City,	Town or Lo	cation		**							City Limits
	Mar.	tor	Maryland N/A			Ba1	timor	е								- 11	es 2 No
	or 28	Director	10e. Street and Number					10f. Zip	Code				•	itizen of V	What Cou	ntry?	
	23a		1162 Washington				1		1230					S.A.		can Indian	
	er de	Funerai	11. Marital Status	Armed	ecedent Everage Forces?		. 13.	was Dece If Yes, spe	cify Cuba	ispanic Ori in, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	3-		k, White		ll l
36	rs aft	by F	Never Married 2 Married     Widowed 4 □ Divorced	Il Yes,	Give or Dates:		ļ	1 🗆 Yes	2 🔀 No	Specify:			1	Specify	Nati	ive Ar	merican
ò	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menial Hyglene. If Item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic event, the Medical Examer must be codified at	ted	15. Decedent's		-0		16a. Dece	dent's Usu	al Decup	ation during mos	t of word	vina	16b. F	Kind of Bu			
215	P. Pin 7.	Completed	(Specify only highest of Elementary/Secondary (0-12)		e (1-4or 5+	)	life.	DO NOT	se retired	i)	101 4017	urig					
2	er thu	Co	8				Pa	ainte	r				1	Pain			
pu	be file d oth event	Be	17. Father's Name (First, Middle, La	st)								e (First, Middle	i, Meidei	n Sumam	10)		
yla	should be ind Mental is marked o	မ	Jessie Chavis	<b>7</b> . <b>9</b> . <b>9</b>		Ī	105 14-16	- A deles a	- (Ct-0.0.4.			Chavis ra <i>l R</i> oute Numb	or City	or Tours	State 7	n Code)	
Mar	12 sh h and 7 is m Iraum		19a. Informant's Name/Relationship Joey Jacobs -	(Type, Print)								ton, NC			Jia10, 27	p 0000)	
e,	is 1 and 2 of Health a Item 27 is		20a. Method of Disposition			20b. Pla	ce of Disno	sition (Na	me of			Date Date			City or T	own, State	
DO .	ages ant of tt: If It		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		om State		metery, crer is Fa				2-	4-04	Ro	wlan	d, N	С	
Baltimore, Maryland 21215-0036	permit. Pages Department of P Important: If Ite any injury or of		21. Signature of Funeral Service Lice							ss of Facility			l				
Ä	permi Depa Impo any in		Men 1.	2008	dQ	21						et Rowla	and,	NC			
	E	- 1	23a. Pent1. Enter the disease, or co	mplications the	at caused t	he death.	Do not ent	ter the mo	de ol dyin	g, such as	cardiac	or respiratory a	arrest,			Approxir Interval	nate Between nd Death
>	Physician	0	tmmediate Cause (Final disease or condition	. Sti	APH	y Lo	Cocci	46	SE	pfi	CE	MIA				Oliset al	IG Death
96	/Medical Examiner		resulting in death)	Due	to (or as a	conseque	ence of):										
	LXammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	to (or as a	conseque	ence ol):										
	ted nsit	Examiner	Cause (Disease or injury	540	10 (01 45 4	001130400	orroo ory.										
	e be executed /sicien and e burial-transit	Exar	that initiated events resulting in death) Last	c	to (or as a	conseque	ence ol):										
760,	eath certificate be executed attending physicien and for use as the burial-transit	cail		d													
89	tifical ng phy as th	Medi	IE ECHALE.	,									T				
Вох	death certifica e attending ph d for use as th	an	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ve birth 2	Fetal	death 3[	]€ctopic p		,					te of deli-	very Day	Year
.O.	O O	Physician/Med	1 Yes 2 No		egnant at t nknown	ime ol dea	ath 5	Other (s	pecify)							,	
<u>α</u>	The law requires that the deatl site has been signed by the atte bage 2 should be detached for		Part II. Other significant condition	contributing t	o death bu	not result	ting in the u	inderlying	cause giv	en in Part I	l.	23e. Did	tobacco	use cont	nbute to	the cause	of death?
Vital Records,	signe d be	d by										1 🗆	Yes 2	2 🗆 No	3 Pro	bably 4	Unknown
cor	w require been si	Completed										24a. Wa:	s an	24b. 1	Were au	opsy findin	gs available
Re	The lav ate has page 2	E G											ormed2		prior to c death? 1 □ Yes	ompletion of	of cause of
tal		e e	25. Was case relerred to medical							26. Place	e of Dea	th (Check only	2√ N one)	0	, , , , ,	20,40	
	Physician: this certific ral director,	0 8	examiner? 1 Yes 2 No	Hospital: 1	Inpatier	t 2 🗆 E	R/Outpatier	nt 3 D	OA Oth	er: 4 🗆 Nu	ursing H	ome 5 Res	idence	6 □Oth	er (Spec	ity)	
υot		n: T	27. Manner of Death		ate of Injury Month, Day		28b. Time o Injury	f	28c. Injur Wor	y at k?		28d. Describe	how inj	ury occur	red		
Sio	death. ctor: Af y the fu	atic	2 Accident investiga					М		Yes 2	No		100				
Division		Certification:	3 Suicide 6 Could no 4 Homicide determin	286. PI	lace of Inju uilding, etc.	y - At hon (Specify)	me, Jarm, st.	reet, lacto	ry, office			28f. Location City or To			er or Hu	rai Houre A	umber,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying	Physicien: To	the best o	my know	vledge, deat	h occurre	at the tir	ne, date ar	nd place	and due to the	cause(	s) and ma	anner as	stated.	
	24 hc 24 hc Fun etely	Medical	(Check only 2 Medical Ex	eminer: On th		examination											e(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		17					e number		_		-		, Dey, Yea	
			Kopita	K.	Cri	Up.	2	1	D00.	303	53		40	anno	ary	28,2	2004
			30. Name and address of person w	10 completed o	cause of de	ath (mem	23a) (Type,	Print)		BON	SF	=cou	75	H	OS P	TAL	1
	- CA	210	31. Date filed (Month, Day, Year)		2. Registra	r's Signati	ure /v	· 1		,00,4		1	-3			, , , , ,	
	St	ate				-	1.0	1	1. 00	~							

DHMH 17 Rev 1/2001

ORIGINAL

	_1	- State Amend Item # RegistrarAMFND ITEM	#30 PER DV	R G828	2/11/04 GA/	tificate of	Death	2. Date of De	Reg. No.		3. Time of Death
sicia	n	1. Decedent's Name (First, Midd Evelyn B. C						Januar	Day	2004	5:00 PM M
edica imine	_	4a. Facility Name (If not institution	-	number)		4b. City, Town, o		th		unty of Death	
		2509 Cecil	Drive 6. Sex	7. Age (I	n yrs. last birthday)	Ches If Under 1 Year	If Under 24 Hrs	s. 8. Date of Bi	th	en An	place (State or Foreign ntry)
ral tor		5. <b>066</b> 27 6463	1□M 2∭F		)1 Yrs.	Months Days	Hours Min	Nov 24	1912	Cou	ntry) unk
	- 1	Usuel Residence of Decedent  10a. State 10b. County	/	10	Oc. City, Town or Lo	cation					10d. Inside City Limits
	ō	MD Que	en Anne's		Ches	ter					1 ☐ Yes 2√☐ No
	Director	10e. Street and Number				10f. Zip Code				of What Cou	intry?
1		2509 Cecil Dr		and and Sug	IIC   12 1	Vas Decedent of H	619	Specify Ves or N		JSA Race - Amer	ican Indian
	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 Mai</li> </ol>	Armed rried 1 ☐ Ye	ecedent Eve Forces? s 2 📉 No		f Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)		Black, White	
100	2	3 X Widowed 4 ☐ Divorce	If Yes.	Give Dates:		1□Yes 2X0No	Specify:			ecify: whi	
	Completed	15. Decede (Specify only highe	nt's Education est grade complete	d)	(Give	ient's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind	of Business/I	ndustry
	dwo	Elementary/Secondary (0-12) unk	unk College	(1-4or 5+)	1	ousewife	•		ow	n home	_
	Be C	17. Father's Name (First, Middle	, Last)				18. Mother's Na	ame (First, Middle	, Maiden Sui	mame)	
	2	Frank Lander E				(0)		es Mitche		Cto to 7	'- Codel
	1	19a. Informant's Name/Relation Michael Cate				ng Address (Street  Cecil D					p (-0de)
	İ	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (		1	20b. Place of Dispo			Date		ion - City or T	own, State
-8500	Ì	21. Signature of Fundal Service		Direc		Name and Addre ate Anat lltimore,			Balti	imore :	Street
in		23a. Part Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	or complications that only one cause of	n each line.		er the mode of dyin	g, such as cardia	ac or respiratory a			Approximate Interval Between Onset and Death
al er		resulting in death)	Due	to (or as a c	onsequence of):	Ne COA	dievari	Jan	L150.	854	years
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a c	onsequence of):			,			
	dicai Exa	that initiated events resulting in death) Last	C. Due	to (or as a c	onsequence of):						
- 1	0	Tage									
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e birth 2 [ egnant at tim	Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>	1		23d	. Date of deliv Month	rery Day Year
	۾	Part II. Other significant condit		death but n		nderlying cause giv	en in Part I.				the cause of death?
1	Completed		رير					24a. Was auto perfe 1 Yes	psy ormed?	prior to co	opsy findings available ompletion of cause of
- 1	Be	25. Was case referred to medic examiner?						eath (Check only	one)		
- 13	tlon: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pend	28a. Da	☐ Inpatient te of Injury onth, Day Y	2 ER/Outpatier 28b. Time of Injury	28c. Injur Wor	y at	Home 5 Res 28d. Describe			ify)
	Certification;	3 Suicide 6 □ Could	not be 28e. Pla	ce of Injury ilding, etc. (	- At home, farm, str (Specify)	eet, factory, office			Street and N wn, State)	umber or Rui	ral Route Number,
	edical (		I Examinar: On the		my knowledge, deatl kamination and/or in d.						
,	Me	29b. Signature and title of certification	er X.	,	11 A	29c. Licens				gned (Month	, Day, Year)
		14/5	7 600	VI	UD	DE	5750		2-4	-04	
3		30. Name and address of person			th (Item 23a) (Type, DAVENUE F Signature		21601	<del>,</del>			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State Registra AMEND ITEM #30 PER DVR G828 2/11/04 Chartificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician January 2004 10:15 AM 22, Edna Virginia Cormack /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Perry Hall Ma Maison Asst Living Baltimore 5. Social Security Number Birthplece (State or Foreign
Country) **Funeral** 1 ☐ M 2 💢 F 218-09-9224 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Itame 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ▼☐ No Perry Hall Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9404 Belair Road 21236 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Benson Smith Annie Dawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13603 Red Squirrel Way Herndon, VA 20171 Susan Jane Krause/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Figure 21 Service Licensee ROnald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director nan Baltimore, MD 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) bdomin **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 3 DOA esidence 6 Other (Specify) Certification; To this 27. Manner of Deal 1 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After s after dea. ral Director: Aftr 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ę Ç 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2-3-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMAD ALBRASH MA MAISON ASSISTED LIVING PERRY HALL, MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 200Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey Year Collins 6:43 P M **Physician** Nellie February 08 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Cit Baltimore Hospital of Sinai If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jun 29, 1944 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** Days 1 ☐ M 2 ☐ XF Md 216-42-3854 59 Vrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or theme 23e or 28e-f show any injury or other traumatic event, It a Medical Examination routiled at once. 1 Yes 2 No **Baltimore** N/A Maryland Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21215 3001 Wylie Ave. by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Rlack 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Commercial Laundry Elementary/Secondary (0-12) College (1-4or 5+) Folder 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norma L. Carter Joseph Carter Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1774 Homestead Street Baltimore, Maryland 21218 Fay Deal Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 02/14/04 Landsdown, Maryland Mt. Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Furieral Service Licenses Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Adenocarcinoma 1 month **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo 4 Pregnant at time of death signed by the a d be detached for ☐ Yes 2 No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 ⊠Unknown mellitus cerebrovascular 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s autopsy performed? 2⊠ No 2 No 1 Yes 1 ☐ Yes 26. Place of Death (Check only one, 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide within 24 hours a

To the Funerel is
completely filled Fo the Hospital t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 02/08/2004 RES OOD MD KITTANE 2401 West Belyedere Avenue Bultimore Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISHNUPRIYA 32 Registrar's Signature 31. Date filed (Month, Play, Year) 2004 State

DHMH 17 Rev 1/2001

Registrar

Sullo

Nellie

		Please	Otate of Manda			•		
		For State	State of Marylar	•	nt of Health and I ete of Death		ZUIII	03999
		State Registrar	an Adial	Certifica	le of Dealif	Reg. N	0.	3. Time of Death
Physicia /Medic		1. Deradent's Name (First, Middle, La	CHIN		,	Modith 3	1- Oxog	064
Examin		4a, Facility Name (If not institution, giy	o street and humberl	tA/ X	Town/of Location of Death		c. County of Death	
Funeral Director	4	XXXXXXV XV NXXX	Sex 2 F 7. Age (in yrs.	Yrs. If Unc	er 1 Year If Under 24 Hrs. S Days Hours Min.	8. Date of Birth	9. Birth	face (State or Foreig
show ad at	20	Usual Residence of Decedent  10a. State 10b. County	100	by. Town or Location	E			1  Yes 2 No
ms 23a or 28a-f show	Funeral Director	10e. Street and Number	CAINE A	16. I	2)/21/3	10g. C	itizen of What Cour	ntry?
or Ite	by Funera	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  Yes 24 No If Yes, Give		redent of Hispanic Origin? (Specify Cuban, Mexican, Puent) 22 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White	ean Indian, etc.
n "natural",	Completed b	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	Year or Dates: ducation ade completed)  ©olleget(1-4or 5+)	16a. Decedent's Us (Give kind of site ADD NDT	sual Occupation work done during most of wor psequenced	king 16b/	Cider of Ousinessin	dustry MEAL
is a factor within the state of	Be	17. Father's Name (First, Middle, Last	N/H	MULHT F	HCCC 18. Mother's Man	ne (First, Middle, Maide	n Sumania) - 14	NE
d z should th and Men ?7 is marke traumatic	2	19a. Informant's Name/Relationship	Type, Print) (Wife	19b. Mailing Addre	ss (Street and Number of Pl	ral Royle Number, City	a) Town/State, Zir	101.2120
20=5		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	Place of Disposition (Accemetery, gematory of	arme of rother place)	Date 2091	ocation - City or To	own, State
Department Department Important: any injury once.		21. Signature of Funeral Service Lice	-17:00 11 11 11 11 11 11 11 11 11 11 11 11 1	22. Name	and Address of Facility IL	GEPHON	12 PG	1.7.10 1.2/2/
Physician /Medical Examiner	er	23a. Part 1. Ther the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Covonay  Due to (or as a conse	Artery quence of): n tral	7.1-10		40	Approximate Interval Between Onset and Death
ysicien and le burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	quence of):				
he death certificate the attending physic ched for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1   Live birth 2   Fet 4   Pregnant at time of 9   Unknown	al death 3 Ectopic			23d. Date of delive Month	ery Day Year
requires that the di een signed by the nould be detached	by	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the	-
hasb	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings availab mpletion of cause o
certificate rector, pag	0	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
S 2	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3		ome 5 Residence	6 □Other (Specif	y)
ath. rr: After		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
Sir to	Certification:	3 Suicide 6 Could not be determined		nome, farm, street, fact ify)	ory, office	28f. Location (Street a City or Town, Sta		al Route Number,
the Hospitel hin 24 hours a the Funeral I npletely filled	edical	(Check only 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	ation and/or investigati	on, in my opinion, death occu	rred at the time, date ar	nd place, and due to	the cause(s)
withir Comp	ž	29b. Signature and title of certifier	)		9c. License number	29d. D	ate signed (Month,	Day, Year)
1		20. Name and address of passes who	completed cause of death (to	m 23a) (Type Print)	D30641	Fel	ruary.	5 2004
٨١		30. Name and address of person who Rames Los Sa	hanalhy	3400 Ex	dman Av	enve B	alhmon	· MD2121
Sta Registr		31. Date filed (Month, Day, Year) FFR 1 1 2004	32. Registrar's Sign	D Soan	61			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item # 22, per FH, G829, 3/3/2004, gap
1- For AMFND ITEM #15&20a=c PER FH G829 13/5/09/enautment of Health and Mental Hygiene
1- For AMFND ITEM #15&20a=c PER FH G829 13/10/4 Chartificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 4, 2004 **Physician** Curtis Culbreath 7:00 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehab Center Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2□ F 45 Yrs. 578-30-6709 Director 29, 1958 Washington DC Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "neturel", or items 23a or 28e-f show traumatic event, the Medical Exer ther must be motified at Prince George'e Clinton 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene. I Hygiene. I other than "neturel", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 11**t**h caregiver private homes permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumatic event, SIRB: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hamp Culbreath Christine Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Franklin/mother 5811 Burgundy Street Capital Heights, MD 20743 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \* 4 ☐ Donation 5. ☐ Other (Specify) in state RIVERDALE CREMATORY 2/10/04 RIVERDALE, MD 21. Signal we of Eureral Service Licensee Konald S. Wad 22. Name and Address of Facility Robert O. Freeman Funeral Services, Inc. Director State Anatomy Baltimore, MD nanny 23a. Aart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1353 H Street-Washington, D.C Immediate Cause (Final disease or condition resulting in death) **Physician** Acquired Immune Depoic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol): Examiner the attenting physician and the dor use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2□ No 1 Yes 1 ☐ Yes 2 11Vo Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ţ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLINTON NURSING &REHAB CENTER CLINTON, MD BAHRAM PISHDAD 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

To the

death with the Maryland

altimore, Maryland 21215-0036

law requires that the death certificate be executed

Division of Vital Records, P.O.

2004